

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08001

1. For State

Registrar

1. Decedent's Name (First, Middle, Last)

Nancy Sue Burkins

2. Date of Death  
Month Day Year  
March 3, 20073. Time of Death  
1052 hrs

4a. Facility Name (if not institution, give street and number)

154 Hollingsworth Manor

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

213-36-9595

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

8. Date of Birth (MM/DD/YYYY)

07/25/1939

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

154 Hollingsworth Manor

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Motel

17. Father's Name (First, Middle, Last)

Ernest B. Love

18. Mother's Name (First, Middle, Maiden Surname)

Mary V. Glass

19a. Informant's Name/Relationship (Type, Print)

Chester Burkins / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Champlain Ct, North East, MD 21901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lawn Croft Crematory

Date

03/07/07

20c. Location - City or Town, State

Lirwood, PA

21. Signature of Funeral Service Licensee

*Edward McClellan*

22. Name and Address of Facility

Strano &amp; Feeley Family Funeral Home

635 Churchmans Road, Newark, DE 19702

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple drug (propoxyphene, thioridazine, and carisoprodol)

Due to (or as a consequence of): intoxication

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#25a, 27, 28a-f, per ME, g865, 3/16/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 3/3/2007

28b. Time of Injury

Fnd 10:45 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

154 Hollingsworth Manor Elkton, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Patricia Aronica-Pollak*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 4, 2007

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 9 2007

32. Registrar's Signature

*James H. Smith*

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00002

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Luther O. Brown</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>5:50 P. M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Northampton Manor Health Care</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>215-14-1972</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>February 5, 1913</b>                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Frederick</b>  | 10c. City, Town or Location<br><b>Frederick</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>368 Madison Street</b>  |  | 10f. Zip Code<br><b>21701</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Minister</b>  |  | 16b. Kind of Business/Industry<br><b>Ministry</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Washington Brown</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth M. Diggs</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Velma Weedon - daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>90 Waverly Drive, Frederick, Maryland 21702</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairview Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Sharon Camille Colvin</i>  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, Maryland 21702</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><br>b. <b>Prostate cancer with bone metastases</b><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>1 year</b> |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Austin Pearre</b>  |  | 29c. License number<br><b>009689</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/26/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Austin A. Pearre, M.D. 300 West 9th Street, Frederick, Maryland 21701</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>  |  | 32. Registrar's Signature<br><i>Kevin H. Sparks</i>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar 3-6-07 Amend 23a.Prt.1.Per Phys. FCC Certificate of Death

Reg. No. 2007 00003

|  |   |  |   |  |  |   |  |  |  |                        |                                     |
|--|---|--|---|--|--|---|--|--|--|------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Pasquale Ciccone</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>12:35 AM</b>  |   |  |  |  |                        |                                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Casey House</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |  |  |  |                        |                                     |
| Funeral<br>Director  | 5. Social Security Number<br><b>146-07-3826</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 16, 1911</b>   | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |   |  |  |  |                        |                                     |
|  | Usual Residence of Decedent   |  |   |  |  |   |  |  |  |                        |                                     |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Seabrook</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |                        |                                     |
|  | 10e. Street and Number<br><b>9517 Dubarry Avenue</b>  |  | 10f. Zip Code<br><b>20706</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |  |                        |                                     |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  |  |                        |                                     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |   |  |  |  |                        |                                     |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>                                |  | 16b. Kind of Business/Industry<br><b>Government</b>  |   |  |  |  |                        |                                     |
|  | 17. Father's Name (First, Middle, Last)<br><b>Vincenzo Ciccone</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Delvechio</b>   |  |  |   |  |  |  |                        |                                     |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosemarie Ciccone (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9517 Dubarry Avenue, Seabrook MD 20706</b>                |  |  |   |  |  |  |                        |                                     |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery 3/2/2007</b>   |  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>  |   |  |  |  |                        |                                     |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Rendon/Hale Funeral Home</b><br><b>9013 Annapolis Road, Lanham MD 20706</b>  |  |  |   |  |  |  |                        |                                     |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |  |  |   |  |  |  |                        |                                     |
| <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <del>Pneumonia</del> <b>Aspiration Pneumonia</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <del>Aspiration</del> <b>Dementia</b></td> </tr> <tr> <td>c. <del>Dementia</del></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |   |  |   |  | Immediate Cause (Final disease or condition resulting in death)  | a. <del>Pneumonia</del> <b>Aspiration Pneumonia</b> | Approximate Interval Between Onset and Death | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <del>Aspiration</del> <b>Dementia</b> | c. <del>Dementia</del> | d. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)  | a. <del>Pneumonia</del> <b>Aspiration Pneumonia</b>   | Approximate Interval Between Onset and Death   |   |  |  |   |  |  |  |                        |                                     |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. <del>Aspiration</del> <b>Dementia</b>  |  |   |  |  |   |  |  |  |                        |                                     |
|  | c. <del>Dementia</del>  |  |   |  |  |   |  |  |  |                        |                                     |
|  | d. Due to (or as a consequence of):   |  |   |  |  |   |  |  |  |                        |                                     |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |                        |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b>   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |  |  |                        |                                     |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |  |  |  |                        |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |  |   |  |  |  |                        |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |   |  |  |  |                        |                                     |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |  |  |                        |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |  |  |   |  |  |  |                        |                                     |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>40058032</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2-26-2007</b>  |  |   |  |  |  |                        |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cynthia M. Williams, D.O. 6001 Muncaster Mill Road, Rockville MD 20855</b>  |   |  |   |  |  |   |  |  |  |                        |                                     |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |                        |                                     |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 080004

1- For State Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)  
Gerald P. Collins

2. Date of Death  
Month Day Year  
February 16, 2007

3. Time of Death  
1010 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)  
602 Crain Highway South

4b. City, Town, or Location of Death  
Glen Burnie

4c. County of Death  
Anne Arundel

5. Social Security Number  
090-40-5481

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
55 Yrs.

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)  
Apr 4, 1951

9. Birthplace (State or Foreign Country)  
NY

Usual Residence of Decedent

10a. State  
MD

10b. County  
Anne Arundel

10c. City, Town or Location  
Glen Burnie

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
602 Crain Highway South

10f. Zip Code  
21061

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 72-92

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
SFC

16b. Kind of Business/Industry  
US ARMY

17. Father's Name (First, Middle, Last)  
Unknown Collins

18. Mother's Name (First, Middle, Maiden Surname)  
Unknown

19a. Informant's Name/Relationship (Type, Print)  
JoAnna Faulkner Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
712 Pamela Road Glen Burnie, MD 21061

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Metro Crematory

Date  
02 27 2007

20c. Location - City or Town, State  
Baltimore, MD

21. Signature of Funeral Service Licensee  
*Patricia A. Smith*

22. Name and Address of Facility  
Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)  
a. Chronic Alcohol Abuse  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED

☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death  
1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
*Jack Titus MD*

29c. License number  
O.C.M.E.

29d. Date signed (Month, Day, Year)  
February 17, 2007

30. Name and address of person who completed cause of death (Item 23a)  
Jack Titus MD Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature  
*James B. Smith*

FEB 27 2007

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08005

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALEX CURRY JR.

2. Date of Death

Month

Day

Year

3. Time of Death

9:39 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

251-42-1946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

AUGUST 12, 1931

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1229 G. ST. SE #12

10f. Zip Code

20003

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ALEX CURRY SR.

18. Mother's Name (First, Middle, Maiden Surname)

ANNA MAE JACKSON

19a. Informant's Name/Relationship (Type, Print)

MARY DEAS/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8905 BLACKBRIAR CT. FT. WASHINGTON, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESURRECTION CEMETERY

Date

3/2/07

20c. Location - City or Town, State

CLINTON, MD

21. Signature of Funeral Service Licensee

Kenny J. Stewart

22. Name and Address of Facility

6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748

STRICKLAND FUNERAL SERVICES, P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Synergistic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael S. Adams

29c. License number

D45365

29d. Date signed (Month, Day, Year)

02-26-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael S. Adams, M.D. 11701 Livingston Rd #101, Fort Washington MD 20746

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Kenny J. Stewart

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08006

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|                                     |  |   |  |  |  |  |  |   |   |  |
|-------------------------------------|--|---|--|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SUZANNE S. COOK</b>                             |   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 22, 2007</b> |  |  |   | 3. Time of Death<br><b>4:15 a M</b>                         |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey Hospice</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>       |  |  |   | 4c. County of Death<br><b>Baltimore City</b>                |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>212-20-1099</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br><b>08-04-1924</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|                                     | Usual Residence of Decedent  |   |  |  | 10a. State<br><b>Maryland</b>                                  |  | 10b. County<br><b>Prince George's</b>                    |   | 10c. City, Town or Location<br><b>Hyattsville</b>           |  |
| To Be Completed by Funeral Director |  | 10e. Street and Number<br><b>3200 Kimberly Road</b>   |  |  |  | 10f. Zip Code<br><b>20782</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
|                                     |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |
|                                     |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personnel Specialist</b>   |  | 16b. Kind of Business/Industry<br><b>D.C. Air National Guard</b>   |  |   |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Robert Spindle</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Suzanne Kidwell</b>  |  |  |  |   |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vivian Lee Whalen - Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3200 Kimberly Road, Hyattsville, MD 20782</b>  |  |   |   |  |
|                                     |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Bladensburg, Maryland</b>  |  |   |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>MD1373</b>   |  | 22. Name and Address of Facility<br><b>4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781</b>  |  |  |  |   |   |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Laryngeal cancer</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>years</b>   |  |  |  |   |   |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                |  | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |   |  |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |   |   |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |  |   |   |  |
|                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |   |  |
|                                     |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |   |   |  |
|                                     |  | 29b. Signature and title of certifier<br><b>E. Tso MD</b>   |  | 29c. License number<br><b>D24170</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 22, 2007</b>  |  |   |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>E. Tso MD Richey Hospice 838 N. Eutaw St Baltimore MD 21201</b>  |  |  |  |  |  |   |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For State Registrar

Reg. No. 2007 08007

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PITTMAN L. CAREY, JR

2. Date of Death  
Month Day Year

MARCH 01 2007

3. Time of Death

0539 M

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

212-36-1823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

8. Date of Birth (Month, Day, Year)

02/10/1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8073 Bowlend Road

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Pittman L. Carey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emily Groton

19a. Informant's Name/Relationship (Type, Print)

Doris J. Miller Carey/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8073 Bowlend Road, Pocomoke, MD 21851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

3/3/2007

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

James L. Deanna, M00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Ave., Princess Anne, MD 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CHF

Due to (or as a consequence of):

Chronic hypoventilation

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

morbid obesity

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joe Raffetto, M.D.

29c. License number

D20447

29d. Date signed (Month, Day, Year)

3-1-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joe Raffetto, M.D. 400 E. Shore Dr. Salisbury MD

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

James L. Deanna

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 00008

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul A. Doerson

2. Date of Death

February 25, 2007

3. Time of Death

9:55 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

714 McKnew Road

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

Anne Arundel

5. Social Security Number

151-20-5042

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
11/20/1927

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

714 McKnew Road

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Fabricator

16b. Kind of Business/Industry

General Construction

17. Father's Name (First, Middle, Last)

Carl

F.

Doerson

18. Mother's Name (First, Middle, Maiden Surname)

Marie

M.

Bowe

19a. Informant's Name/Relationship (Type, Print)

Martha Gulley Daughter-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1064 Brightleaf Drive Arnold, MD 21012

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Cemetery

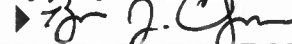
Date

Feb. 28, 07

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service licensee



22. Name and Address of Facility

Hardesty Funeral Home P.A. 851 Annapolis Rd.  
Gambrills, MD 21054

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Yes ☐ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D39505

29d. Date signed (Month, Day, Year)

February 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Marwan 305 Hospital Drive, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08009

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA GRACE DOVE

2. Date of Death

February 23, 2007

3. Time of Death

2:44 a<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

579-01-3131

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-29-1917

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5620 31st Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teaching Aide

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Melvin William Cogar

18. Mother's Name (First, Middle, Maiden Surname)

Ola Violet Watson

19a. Informant's Name/Relationship (Type, Print)

Jeffrey Dove - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5719 Sheridan Street, Riverdale, Maryland 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

George Washington Cem.

Date

3/1/2007

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

4739 Baltimore Ave.  
Gasch's Funeral Home, P.A. Hyattsville, MD 2078123a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Atherosclerotic Coronary Artery disease

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D52326

29d. Date signed (Month, Day, Year)

February 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Kennedy Lightfoot, Jr., MD Washington Adventist Hospital, Takoma Park, MD

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Brian A. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08010

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Hermogenes Cada Deasis

2. Date of Death

February 25, 2007

3. Time of Death

1040A M

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

213-96-3147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 12, 1948

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11410 Fort Saratoga Court

10f. Zip Code

20744

10g. Citizen of What Country?

Philippines

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Filipino

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Patricio

Deasis

18. Mother's Name (First, Middle, Maiden Surname)

Felisa Cada

19a. Informant's Name/Relationship (Type, Print)

Felicita Veluz / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3210 Barcroft Drive Springdale, Maryland 20774

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

03/04/2007

20c. Location - City or Town, State

Edgewater, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home PA  
6160 Oxon Hill Road Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Acute Coronary Disease

Approximate Interval Between Onset and Death

years

b. Due to (or as a consequence of):

Diabetes Mellitus

years

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Remsen

29c. License number

D19446

29d. Date signed (Month, Day, Year)

February 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Remsen, MD - 575 Main Street, Suite 351, Laurel, MD. 20707

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Steven A. Spade

State Registrar

Deasis, Hermogenes  
Baltimore, Maryland 21215-0036Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08011

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Lucy Dudley

2. Date of Death  
Month Day Year  
February 23, 20073. Time of Death  
0100 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Rehab &amp; Nursing Center

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

5. Social Security Number

016-07-3053

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Mar 26, 1910

9. Birthplace (State or Foreign  
Country)

Vermont

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6627 Deep Run Parkway

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Entrepreneur

17. Father's Name (First, Middle, Last)

Elias Stowell

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Robinson

19a. Informant's Name/Relationship (Type, Print)

June Wedeking Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6627 Deep Run Pkwy. Elkridge, MD 21075

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremation Inc

Date

2/23/07

20c. Location - City or Town, State

Hamstead, Maryland

21. Signature of Funeral Service Licensee

John K. Self

22. Name and Address of Facility

Pritts Funeral Home & Chapel, PA  
412 Washington Rd. Westminster, MD 2115723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown☐ Ectopic pregnancy  
☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John K. Self

29c. License number

D15872

29d. Date signed (Month, Day, Year)

February 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harold B. B. M. 25 Main Street

Regester, MD  
21134

31. Date filed (Month, Day, Year)

FEB 26 2007

32. Registrar's Signature

John K. Self

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WJZ  
2State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08012

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert LeRoy Davidson

2. Date of Death

Month Day Year

2

27

2007

7:00 A.

M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

4202 Black Rock Road

4b. City, Town, or Location of Death

Hampstead

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

217-12-2698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8/27/1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4202 Black Rock Road

10f. Zip Code

21074

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 1942-  
If Yes, Give  
Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Farm Supply Company

17. Father's Name (First, Middle, Last)

Earl Davidson

18. Mother's Name (First, Middle, Maiden Surname)

Grace Switzer

19a. Informant's Name/Relationship (Type, Print)

Virginia Davidson--Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4202 Black Rock Road, Hampstead, MD 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mark's (Snydersburg)

Date

3/2/2007

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

Steven W. Elmer M00723

22. Name and Address of Facility

Eline Funeral Home, 934 South  
Main Street, Hampstead, Maryland 2107423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Carcinoma of the right lung with metastasis to brain

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Deogracias V. Faustino MD

29c. License number

012901

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deogracias V. Faustino 411 Lower Beckleysville Road, Hampstead, Md 21074

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

Steven W. Elmer

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.WJL  
6+IVA

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08013

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>PATRICIA ANN DI MISA</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> Year <b>2007</b>   |  |  |  | 3. Time of Death<br><b>6:52 AM</b>                                      |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Civista Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>LaPlata</b>   |  |  |  | 4c. County of Death<br><b>Charles</b>                                   |  |  |  |
| 5. Social Security Number<br><b>579-50-0891</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC 21, 1937</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON DC</b>        |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |  |   |  | 10b. County<br><b>CHARLES</b>  |  |  |  | 10c. City, Town or Location<br><b>WALDORF</b>                           |  |  |  |
| 10e. Street and Number<br><b>2308 PINEFIELD ROAD</b>  |  |   |  | 10f. Zip Code<br><b>20601</b>  |  |  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                       |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT J. SHELTON</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>INEZ M. THOMPSON</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KATHY M. HUGHES - DAUGHTER</b>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2301 PINEFIELD ROAD, WALDORF, MARYLAND 20601</b> |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON NAT'L. CEM.</b>   |  |  |  | 20c. Location - City or Town, State<br><b>ARLINGTON, VIRGINIA</b>       |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Mark M. Brohman</b>   |  |   |  | 22. Name and Address of Facility<br><b>HUNTT FUNERAL HOME</b><br><b>3035 OLD WASHINGTON RD., WALDORF, MD 20601</b>   |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

|  |  |                                       |  |   |  |  |  |
|--|--|---------------------------------------|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Kidney Failure</b>   |  |                                       |  | Approximate Interval Between Onset and Death<br><b>Weeks</b>  |  |  |  |
| Due to (or as a consequence of):<br><b>metastatic kidney Cancer</b>  |  |                                       |  | Months  |  |  |  |
| Due to (or as a consequence of):   |  |                                       |  |   |  |  |  |
| Due to (or as a consequence of):   |  |                                       |  |   |  |  |  |
| Due to (or as a consequence of):   |  |                                       |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |                                       |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |                                       |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus, Hypertension</b><br><b>Hypothyroidism, Hyperlipidemia</b>  |  |                                       |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year) |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                       |  | 28d. Describe how injury occurred   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                       |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                       |  | 29b. Signature and title of certifier<br><b>R. Sindhvani</b>  |  |  |  |
| 29c. License number<br><b>D- 61614</b>   |  |                                       |  | 29d. Date signed (Month, Day, Year)<br><b>February 26, 2007</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ravinder K. Sindhvani 11350 Pembroke Sq. Suite 304 Waldorf, MD 20603</b>  |  |                                       |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>  |  |                                       |  | 32. Registrar's Signature<br><b>Ravinder K. Sindhvani</b>   |  |  |  |

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08014

1- For State Registrar

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Justin Robert Dowell

2. Date of Death  
Month Day Year  
March 8, 20073. Time of Death  
0109 hrs

4a. Facility Name (if not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

218-15-7915

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

JAN 14, 1981

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

130 Farah Drive

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Warehouse

17. Father's Name (First, Middle, Last)

Robert Dean Dowell

18. Mother's Name (First, Middle, Maiden Surname)

Rhonda Lynn Grey

19a. Informant's Name/Relationship (Type, Print)

Robert D. Dowell/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 Farah Drive, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cherry Hill Methodist Cemetery

Date

March 10, 2007

20c. Location - City or Town, State

Cherry Hill, Maryland

21. Signature of Funeral Service Licensee

*Donna E. Hicks*

22. Name and Address of Facility

Hicks Home for Funerals, P.A.  
103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Methadone intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Last

Last

☒ UNPENDED☐ AMENDED

#23a, 27, 28a-f, per ME, g865, 3/16/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☒ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 3/27/2007

28b. Time of Injury

Fnd 11:55 pm

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

130 Farah Dr. Elkton, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Melissa Brassell, MD*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2007

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

*Justin Robert Dowell*

State Registrar

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08015

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annette Marie Ellsworth

2. Date of Death

March 8, 2007

3. Time of Death

12:05 A.M.

4a. Facility Name (If not institution, give street and number)

Buckingham's Choice Health Care

4b. City, Town, or Location of Death

Adamstown

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

483-03-9752

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 23, 1917

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3200 Bakers Circle

10f. Zip Code

21710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Academic Advisor

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

John J. Degnan

18. Mother's Name (First, Middle, Maiden Surname)

Anna Nigg

19a. Informant's Name/Relationship (Type, Print)

Joan McConville/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24808 Showbarn Circle, Damascus, MD 20872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Souls Cemetery March 12, 2007

Date

20c. Location - City or Town, State

Germantown, Maryland

21. Signature of Funeral Service Licensee

Richard C. Basford MO0021

22. Name and Address of Facility

Keeney and Basford Funeral Home

306 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Parkinson/Dementia

Approximate Interval Between Onset and Death

Years

a. Due to (or as a consequence of):

Failure to Thrive

Weeks

b. Due to (or as a consequence of):

Hypernatremia

Weeks

c. Due to (or as a consequence of):

Renal Insufficiency

Weeks

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Allen Reilly MD

29c. License number

D54749

29d. Date signed (Month, Day, Year)

March 9, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Reilly, M.D., 801 Toll House Avenue, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

Karen B. Spoke

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 02016

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Glennette Everett

2. Date of Death

March 6, 2007

3. Time of Death

8:09 A M

4a. Facility Name (If not institution, give street and number)

310 Pennsylvania Avenue

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

220-40-2194

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct 11, 1943

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

310 Pennsylvania Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Adam Scarpelli

18. Mother's Name (First, Middle, Maiden Surname)

June Lease Clay

19a. Informant's Name/Relationship (Type, Print)

Kelly Everett daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 Pennsylvania Cumberland MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Scarpelli Funeral Home, P.A.

Date

3/9/2007

20c. Location - City or Town, State

Cresaptown MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
108 Virginia Avenue, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt; 24 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

7-10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23371

29d. Date signed (Month, Day, Year)

3-8-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Qamar Zaman M.D. 625 Kent Avenue Cumberland MD 21502

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08017

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE L. EARLY

2. Date of Death

FEB.

24

2007

3. Time of Death

10:00p M

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

577-38-2711

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAY 6,

1928

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

CLINTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8207 BATHGATE COURT

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWNED HOME

17. Father's Name (First, Middle, Last)

AUGUSTUS SURRATT

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE HILYER

19a. Informant's Name/Relationship (Type, Print)

BARBARA J. POWELL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8207 BATHGATE CT. CLINTON, MD 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WASHINGTON NATL. CEM.

Date

3/5/07

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Kenya Stewart

22. Name and Address of Facility

STRICKLAND FUNERAL SERVICES, P.A.

6500 ALLENTOWN RD.

CAMP SPRINGS, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Cerebrovascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rita F. M.D.

29c. License number

D43446

29d. Date signed (Month, Day, Year)

2.26.07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROHMAN FARAHIFAR M.D. 9801 Georgia Ave suit 3-41 Silver Spring MD 20902

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Barbara A. Spade

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08018

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RACHELLE CATHLEEN EVANS

2. Date of Death  
Month Day Year

FEB. 26, 2007

3. Time of Death  
M

1628 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

214-08-1302

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

30

8. Date of Birth (Month, Day, Year)

NOV. 14, 1976

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

LAUREL

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9060 STEBBING WAY, APT. D

10f. Zip Code

20723

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CHEF

16b. Kind of Business/Industry

FOOD SERVICE

17. Father's Name (First, Middle, Last)

OTIS TALLEY, JR.

18. Mother's Name (First, Middle, Maiden Surname)

BRENDA BOLDEN TALLEY

19a. Informant's Name/Relationship (Type, Print)

JUSTIN EVANS - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9060 STEBBING WAY, APT. D, LAUREL, MD 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY

Date

03/06/07

20c. Location - City or Town, State

CHELTENHAM, MD

21. Signature of Funeral Service Director

LYDIA C. THORNTON JOHNSON

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.  
3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DDA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

OBAFEMI OPESANMI MD

29c. License number

00043606

29d. Date signed (Month, Day, Year)

2/26/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OBAFEMI OPESANMI, MD, 7503 SURRATTS ROAD, CLINTON, MD 20735

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08019

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NORVAL EUGENE EYLER

2. Date of Death

February 25, 2007

3. Time of Death

9:20 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9602C Rocky Ridge Road

4b. City, Town, or Location of Death

Rocky Ridge

4c. County of Death

Frederick

5. Social Security Number

215-20-8018

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 26, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Rocky Ridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9602C Rocky Ridge Road

10f. Zip Code

21778

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Brick Company

17. Father's Name (First, Middle, Last)

Bruce P. Eyer

18. Mother's Name (First, Middle, Maiden Surname)

Lutie Singer

19a. Informant's Name/Relationship (Type, Print)

Ralph L. Eyer / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9606 Rocky Ridge Road, Rocky Ridge, MD 21778

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.R. Ch. of the Brethren 2/28/07

Date

20c. Location - City or Town, State

Rocky Ridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
615 EAST MAIN STREET, THURMONT, MD 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

MDC-15416 C

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kelly P. Miller, MD Gettysburg, PA

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08020

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM F. EVANS

2. Date of Death  
Month Day Year

February 25 2007 1638 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

212-40-9944

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

8. Date of Birth (Month, Day, Year)

DEC 25, 1941

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

208 TALBOT ST.

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

IRVING EVANS

18. Mother's Name (First, Middle, Maiden Surname)

IDA GREENWOOD

19a. Informant's Name/Relationship (Type, Print)

SALLY EVANS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 TALBOT ST., EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRING HILL CEMETERY 3/2/2007

Date

20c. Location - City or Town, State

EASTON, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 hr

20 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, obesity  
Hypertension  
Smoking

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41723

29d. Date signed (Month, Day, Year)

2/26/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC Rajasingh 522 Idlewild Avenue Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

William Evans

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08021

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA RUTH EASON

2. Date of Death

Month Day Year  
FEBRUARY 23 2007

3. Time of Death

5:22PM M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WILLIAM HILL MANOR

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

219-05-8870

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 6, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

501 DUTCHMANS LANE

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FLOYD WILMER COLEMAN

18. Mother's Name (First, Middle, Maiden Surname)

EMMA M. FLUHARTY

19a. Informant's Name/Relationship (Type, Print)

CYNTHIA L. EASON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 SEYMOUR AVE., ST. MICHAELS, MD 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRING HILL CEMETERY

Date

2/28/2007

20c. Location - City or Town, State

EASTON, MARYLAND

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA  
200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month.

7 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation  
Hypertension.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Russell Schilling

29c. License number

1442587

29d. Date signed (Month, Day, Year)

02-26-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell Schilling 555 Cynwood Dr Easton MD 21601

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 03022

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frances H. Fox

2. Date of Death

February 19 2007

3. Time of Death

5:34P M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-01-1268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Woodsboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 S. Second St.

10f. Zip Code

21798

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

office clerk

16b. Kind of Business/Industry

retail/agriculture

17. Father's Name (First, Middle, Last)

Marshall P. Winebrenner

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Dudderar

19a. Informant's Name/Relationship (Type, Print)

Betty Eyler/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 N. Second St. Woodsboro, MD 21798

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Hope Cemetery

Date

2/22/2007

20c. Location - City or Town, State

Woodsboro, MD

21. Signature of Funeral Service Licensee

Catherine O. Dangler

22. Name and Address of Facility

Hartzler Funeral Home  
404 S. Main St. Woodsboro, MD 2179823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Stroke

Due to (or as a consequence of):

b. Atrial fibrillation

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

W. Nguyen

29c. License number

D47705

29d. Date signed (Month, Day, Year)

2/20/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. MINH-THU NGUYEN, 1564 Openmoun Pike, Frederick, Md 21702

31. Date filed (Month, Day, Year)

FEB 26 2007

32. Registrar's Signature

K. H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08023

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BELETU DEBEBE GEBREWOLD

2. Date of Death

Feb. 27, 2007

3. Time of Death

14:10 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Ft. Washington, MD

4c. County of Death

P.G.

5. Social Security Number

214-51-2462

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-16-30

9. Birthplace (State or Foreign Country)

Ethiopia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4208 Flam Street

10f. Zip Code

20744

10g. Citizen of What Country?

Ethiopia

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Ethiopian

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Debebe Gebrewold

18. Mother's Name (First, Middle, Maiden Surname)

Negatua Abeyou

19a. Informant's Name/Relationship (Type, Print)

Gerum Arega/Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4208 Flam Street, Ft. Washington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Michaels Cemetery

Date

3/4/07

20c. Location - City or Town, State

Addis Ababa, Ethiopia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Frazier's Funeral Home, Inc.

389 Rhode Island Avenue, N.W., Wash., DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic liver carcinoma

Approximate  
Interval Between  
Onset and Death

months

Due to (or as a consequence of):

b. liver cirrhosis

year

Due to (or as a consequence of):

c. Hepatitis C

year

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☒ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. M. Aleblaw MD

29c. License number

MD 46046

29d. Date signed (Month, Day, Year)

2-27-2007

30. Name and address of person who completed cause of death (Item 2a type, Print)

11711 Livingston Road, Ft. Washington, MD 20744

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08024

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert GANNAWAY

2. Date of Death

Feb 24 2007

3. Time of Death

2025<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

306 Charred Oak Court

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

214-38-8154

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

Nov. 11, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1□Yes XXNo

10e. Street and Number

306 Charred Oak Court

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

XXNever Married 2□Married

3□Widowed 4□Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2□No

If Yes, Give Year or Dates: 1962-

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes XXNo Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Frozen Food Manager

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Donovan F. Gannaway

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Marie Wayson

19a. Informant's Name/Relationship (Type, Print)

Kathryn A. Beggs / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8391 Hamburg State Park Rd. Mitchell, GA 30820

20a. Method of Disposition

XXBurial 2□Cremation 3□Removal from State

4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Hallows Cemetery

Date

2/28/2007

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

Michael J. Taylor

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.  
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1□Yes 2□No

9□Unknown

23c. If yes, outcome of pregnancy

1□Live birth 2□Fetal death

4□Pregnant at time of death

9□Unknown

3□Ectopic pregnancy

5□Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3□Probably 4XXUnknown

24a. Was an autopsy performed?

1□Yes 2XXNo

24b. Were autopsy findings available prior to completion of cause of death?

1□Yes 2□No

25. Was case referred to medical examiner?

1XXYes 2□No

26. Place of Death (Check only one)

Hospital:

1□Inpatient

2□ER/Outpatient

3□DOA

Other:

4□Nursing Home

5XXResidence

6□Other (Specify)

27. Manner of Death

1XXNatural

2□Accident

3□Suicide

4□Homicide

5□Pending investigation

6□Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□Yes 2□No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□

2XX

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, MD

29c. License number

D06054

29d. Date signed (Month, Day, Year)

2/20/17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

Ann B. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08025

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JAMES JOSEPH GAMBINO, SR.

2. Date of Death  
Month Day Year

February 24, 2007

3. Time of Death

12:50 a<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

108 Thomas Jefferson Street

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

578-42-9565

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

8. Date of Birth

If Under 1 Year Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

06-30-1935

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 Thomas Jefferson Street

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1955-

1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Office

16b. Kind of Business/Industry

Bakers International

17. Father's Name (First, Middle, Last)

Frank Gambino

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Gillespie

19a. Informant's Name/Relationship (Type, Print)

Irene F. Gambino - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Thomas Jefferson Street, LaPlata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Cemetery

Date

3/16/2007

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

[Signature] 9701373

22. Name and Address of Facility

Gasch's Funeral Home, P.A. 4739 Baltimore Ave.

Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D0056949

29d. Date signed (Month, Day, Year)

2/24/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARAKSHI BAIG M.D. 6620 CRAIN HWY. STE 102 LA PLATA MD 20646

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08026

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ROSE MARY GILBERT</b>   |  | 2. Date of Death<br>Month Day Year<br><b>02-17-07</b>   |   | 3. Time of Death<br><b>6:55 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>ST. CATHERINES NURSING CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>EMMITSBURG</b>   |   | 4c. County of Death<br><b>FREDERICK</b>  |  |
| 5. Social Security Number<br><b>293-4-9882</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>03-04-23</b>  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Westminster</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1162 Canon Way</b>  |  | 10f. Zip Code<br><b>21157</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>  |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>High School Teacher</b>  |  | 16b. Kind of Business/Industry<br><b>Education</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Paul Greenwald</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Schneider</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane A. Gilbert Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2208 Erin Way Bel Air, MD 21015</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>South Carroll Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Winfield, MD</b>   |  |
| 21. Signature of Funeral Service Liaison<br><b>Sam B. Cammy</b>  |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Home &amp; Crematory, PA<br/>1212 W. Old Liberty Road Winfield, MD 21784</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LEFT LOWER LOBE PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>ADVANCED ALZHEIMERS DEMENTIA, SEVERE</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of): |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>ARRHYTHMIA</b><br><b>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Andrew Farkas</b>  |  | 29c. License number<br><b>D0064288</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>02-17-07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANDREW FARKAS MD</b>  |  | <b>FAIRFIELD PA 4910-A Fairfield Rd. 17320</b>  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 21 2007</b>  |  | 32. Registrar's Signature<br><b>Sharon B. Smith</b>   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

WJZ  
8State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08027

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |                                      |  |  |   |   |
|---|---|---|---|--------------------------------------|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ERNEST WILLIAM GATES</b>   |   |   |                                      | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 26, 2007</b>   |  | 3. Time of Death<br><b>12:51 A M</b>                                    |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7800 ANN HARBOR DRIVE</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>PORT TOBACCO</b>  |  | 4c. County of Death<br><b>CHARLES</b>                                   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-20-5634</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 8, 1921</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|   | Usual Residence of Decedent   |   |   |                                      |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>CHARLES</b>   | 10c. City, Town or Location<br><b>PORT TOBACCO</b>  |                                      |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |
|   | 10e. Street and Number<br><b>7800 ANN HARBOR DRIVE</b>  |   |   | 10f. Zip Code<br><b>20677</b>        |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1954</b>  |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PLUMBER</b>   |                                      | 16b. Kind of Business/Industry<br><b>CIVIL STEAM FITTER</b>  |  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>THEODORE PHILLIP GATES</b>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE LAURIE RAUM</b>  |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET T. GATES - WIFE</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7800 ANN HARBOR DR., PORT TOBACCO, MD 20677</b>  |  |   |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HUNTT CREMATORY</b>  |                                      | Date<br><b>FEBRUARY 27, 2007</b>   |  | 20c. Location - City or Town, State<br><b>WALDORF, MARYLAND</b>         |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Mark M. Brohanian</b> M00053  |   | 22. Name and Address of Facility<br><b>HUNTT FUNERAL HOME</b><br><b>3035 OLD WASHINGTON RD., WALDORF, MD 20601</b>  |                                      |  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hepatocellular Carcinoma</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                      |  |  |   |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                      | 23d. Date of delivery<br>Month Day Year  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                                      |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                                      |  |  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                      |  |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |                                      |  |  |   |   |
| 29b. Signature and title of certifier<br><b>William T. Tanner</b>   |   |   |   | 29c. License number<br><b>D35206</b> |  | 29d. Date signed (Month, Day, Year)<br><b>February 26, 2007</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William T. Tanner 11701 Livingston Road, Fort Washington, Maryland</b>   |   |   |   |                                      |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |   | 32. Registrar's Signature<br><b>Heaven St. James</b>  |   |                                      |  |  |   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08028

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred A. Houghton

2. Date of Death

Month Day Year  
March 6 2007

3. Time of Death

5:40 A.M.

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

203-20-6948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

8. Date of Birth (Month, Day, Year)

12-16-21

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Adams

10c. City, Town or Location

Fairfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20 Grasshopper Lane

10f. Zip Code

17320

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Asst. Module Manager

16b. Kind of Business/Industry

Social Security Admin.

17. Father's Name (First, Middle, Last)

Paul Miller

18. Mother's Name (First, Middle, Maiden Surname)

Hazel McClain

19a. Informant's Name/Relationship (Type, Print)

William L. Morton, grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2705 Overview Drive Hampstead, Maryland 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Northumberland Memorial Park

Date

03-09-07

20c. Location - City or Town, State

Northumberland, Pa.

21. Signature of Funeral Service Licensee

J. L. Davis

22. Name and Address of Facility

J. L. Davis Funeral Home 12525 Bradbury Ave Smithsburg, MD 21782

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Congestive heart failure

b. Due to (or as a consequence of):

coronary artery disease

c. Due to (or as a consequence of):

Renal failure

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. L. Davis

29c. License number

D43977

29d. Date signed (Month, Day, Year)

March 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Crescioni, 301 Hospital Drive Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

MAR 14 2007

Registrar's Signature

J. L. Davis

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
MILDRED HOUGHTON  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760, 448

12

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08029

1- For State Registrar

|  |   |  |  |   |   |   |   |   |  |  |  |  |
|--|---|--|--|---|---|---|---|---|--|--|--|--|
| Physician / Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CLAUDE RICARDO HAMILTON</b>                            |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 7, 2007</b>    |   |   |   | 3. Time of Death<br><b>7:15 AM</b>                           |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>CHARLOTTE HALL VETERANS HOME</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>CHARLOTTE HALL</b> |   |   |   | 4c. County of Death<br><b>ST. MARY'S</b>                     |  |  |  |
| Funeral Director   | 5. Social Security Number<br><b>216-30-2780</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>70</b>                   |   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 13, 1936</b> |   | 9. Birthplace (State or Foreign Country)<br><b>WASH., DC</b> |  |  |  |
|  | 10a. State<br><b>MARYLAND</b>   |  |  |   | 10b. County<br><b>CHARLES</b>                                 |   | 10c. City, Town or Location<br><b>LA PLATA</b>              |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>118 HAWTHORNE GREENE CIRCLE</b>   |   |  |  | 10f. Zip Code<br><b>20646</b>   |   |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>AIR FORCE</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>REAL ESTATE DEVELOPER</b>   |   |   |   | 16b. Kind of Business/Industry<br><b>OWN SELF</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>LLOYD HAMILTON</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALVERTA ANDERSON</b>  |   |   |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOY HAMILTON-WIFE</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>118 HAWTHORNE GREENE CIRCLE, LA PLATA, MD 20646</b>   |   |   |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEM. GDNS.</b>  |  | Date<br><b>3-12-07</b>  |   | 20c. Location - City or Town, State<br><b>WALDORF, MARYLAND</b>                             |   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00479</b>   |   |  |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.</b><br><b>LA PLATA, MARYLAND 20646</b>   |   |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Chron's Disease</b><br>Due to (or as a consequence of):<br><b>hypertension</b><br>Due to (or as a consequence of):<br><b>Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>ADVANCED ALZHEIMER'S DEMENTIA</b> |   |  |  | Approximate Interval Between Onset and Death<br><b>Years</b>  |   |   |   |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |   | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b><br><b>hyperlipidemia</b>   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  | 29b. Signature and title of certifier<br><br><b>Paul Fleming</b>  |   |   |   | 29c. License number<br><b>D45092</b>  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/07/2007</b>  |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>110 Hospital Road Suite #205 Prince Fredrick, MD 20678</b>   |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 2007</b>  |   |  |  | 32. Registrar's Signature<br>   |   |   |   |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jacqueline L. Hickcox</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> , Year <b>2007</b>  |   | 3. Time of Death<br><b>4:15 A M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>7050 Albany Avenue</b>  |  | 4b. City, Town, or Location of Death<br><b>North Beach</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| 5. Social Security Number<br><b>220-54-0703</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>3/26/1949</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |   |   |  |   |
| Usual Residence of Decedent  |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>North Beach</b>  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 10e. Street and Number<br><b>7050 Albany Avenue</b>  |  | 10f. Zip Code<br><b>20714</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>In Flight Supervisor</b>  |   | 16b. Kind of Business/Industry<br><b>U.S. Air</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>John Preston Hook</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellen L. Buck</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Douglas L. Hickcox/ Husband</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7050 Albany Avenue, North Beach, MD 20714</b> |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b>  |   | 20c. Location - City or Town, State<br><b>2-27-07 Edgewater, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Rd. Edgewater, MD 21037</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Uterine Sarcoma</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>1 yr</b> |  |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |   |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |   |  |   |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>018522 MD</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>26 Feb 07</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2009 TIDEWATER Colony Dr., Annapolis, MD 21401, Jan B. Lawrence</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 27 2007</b>  |  | 32. Registrar's Signature<br>   |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08031

1- For  
State  
Registrar

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Michael Thomas Hagan</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> , Year <b>2007</b>   |  | 3. Time of Death<br><b>5:05 A M</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>416 Dutch Drive</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Lothian</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-14-5889</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>9/25/1925</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director                                | Usual Residence of Decedent  |  |   |  |  |  |  |  |
|  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Lothian</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>416 Dutch Drive</b>   |  |   |  | 10f. Zip Code<br><b>20711</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-46</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Appraiser</b>   |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Peter J. Hagan</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Gerhardt</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rita D. Hagan/ Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>416 Dutch Drive, Lothian, MD 20711</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b>  |  | Date<br><b>2-26-07</b>   |  | 20c. Location - City or Town, State<br><b>Edgewater, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home</b><br><b>2973 Solomons Island Rd. Edgewater, MD 21037</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Adenocarcinoma of the Lung</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of): |  |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>Four months</b> |  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |  | 3. Ectopic pregnancy<br><input type="checkbox"/> Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D38563</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 26, 2007</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wayne D. Bierbaum MD 134 Owensville Road, West River MD</b>   |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 27 2007</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 06032

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY SCOTT HINSON

2. Date of Death

FEBRUARY 24 2007

3. Time of Death

4:20PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NATIONAL INSTITUTES OF HEALTH

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

420-23-161

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

21

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 3, 1986

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

AL

10b. County

10c. City, Town or Location

Dothan

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1700 Hodgesville Rd. Lot 1010

10f. Zip Code

36301

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Clyde Barnes Hinson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Rowe

19a. Informant's Name/Relationship (Type, Print)

Margaret Hinson/Grandmother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Hodgesville Rd. Lot 1010 Dothan, AL. 36301

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

First United Methodist Ch. Cem.

Date

3-2-2007

20c. Location - City or Town, State

Cottondale, FL.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.  
4217 9th st. N.W. Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. malignant peripheral nerve sheath tumor

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1h, 5min  
2 1/2 mos.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

bone marrow failure  
malnutrition

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Courtney Fitzhugh

29c. License number

00062955

29d. Date signed (Month, Day, Year)

02/24/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COURTNEY FITZHUGH

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08033

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Linda F. Herndon

2. Date of Death

Month Day Year  
Feb 21 2007

3. Time of Death

12 40 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

264-92-9989

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 12, 1948

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2L Eastway

10f. Zip Code

20770

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Paul Clifton Herndon

18. Mother's Name (First, Middle, Maiden Surname)

Mary Iris Caplinger

19a. Informant's Name/Relationship (Type, Print)

Rhea Shariati (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13002 5th Street, Bowie, MD 20720

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

3/1/2007

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home  
9013 Annapolis Road, Lanham MD 2070623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Gram negative Bacteremia

Due to (or as a consequence of):

c. Acute Fulminant Hepatic Failure

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

AM4176435H16777

29d. Date signed (Month, Day, Year)

Feb 21 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary G. Haley 22501 Greene Street Baltimore 21201

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

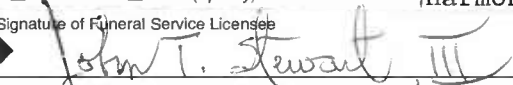
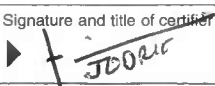

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08034

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Earnestine L. Hall</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 22 2007</b>  |  |  |  | 3. Time of Death<br><b>22:24P M</b>  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |  |  |  | 4c. County of Death<br><b>Prince George's</b>  |  |   |  |
| 5. Social Security Number<br><b>437-62-2839</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 4, 1941</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Louisiana</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>Prince George's</b>  |  |  |  | 10c. City, Town or Location<br><b>Temple Hills</b>   |  |   |  |
| 10e. Street and Number<br><b>4218 Beach Craft Court</b>   |  |   |  | 10f. Zip Code<br><b>20748</b>  |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietary Specialist III</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fester Franklin</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida C. Lewis</b>   |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Livia J. Hall/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4313 Lakeview Dr., Temple Hills, MD 20748</b>  |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |  |  |  | 20c. Location - City or Town, State<br><b>Landover, MD</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b><br><b>4001 Benning Rd., NE Wash., DC 20019</b>   |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death                    |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                    |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M                                   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                               |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D40324</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 23, 2007</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TERRY JORDAN, MD 7883 SUGAR HILLS ROAD, CLINTON, MARYLAND</b>  |  |   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08035

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ruth E Harper</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>7:00 AM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Millennium- Ft. Washington</b>   |  | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |   |
| 5. Social Security Number<br><b>579-42-2113</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>105</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>10/05/1901</b>                     |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince Georges</b>                                       | 10c. City, Town or Location<br><b>Largo</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>500 N Harry Truman Drive Apt304</b>  |  | 10f. Zip Code<br><b>20774</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Caretaker</b>   |  | 16b. Kind of Business/Industry<br><b>Domestic</b>   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Brown</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Joanne Middleton</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth Turner / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3685 Iowa Road Brandywine, Maryland 20613</b>   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Nottingham Myers</b>   |  | 20c. Location - City or Town, State<br><b>03/03/07 Upper Marlboro, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Adams Funeral HomePA<br/>20605 Aquasco Rd Aquasco, Maryland 20608</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |   |
| Approximate Interval Between Onset and Death<br><b>hours</b><br><b>years</b><br><b>years</b>  |  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                                     |  | 23d. Date of delivery<br>Month <b>February</b> Day <b>25</b> Year <b>2007</b>  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia</b><br><b>Cerebrovascular Accident</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D32800</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb. 27, 2007</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Herbert Washington, M.D. 11701 Livingston Road# 205 Ft. Washington</b>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | 32. Registrar's Signature<br>  |  | Md 20744   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08036

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Josephine Frances Herlihy

2. Date of Death

February 26, 2007

3. Time of Death

9:20 P M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

190-20-4675

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 12 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19305 Club House Road #104

10f. Zip Code

20886

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Frisina

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Brescione

19a. Informant's Name/Relationship (Type, Print)

Laura Beth Pohopin/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

598 N. Pines Trail Parker, CO 80138

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

02/28/07

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784  
M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia M Williams DO

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

2-27-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Kuan H. Spill

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08037

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Glen Hazlehurst

2. Date of Death

Month Day Year  
February 27, 2007

3. Time of Death

6:20 P M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

143-18-3918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11505 Piney Lodge Road

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Head Start Administrator Program

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charles Hazlehurst

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Glen

19a. Informant's Name/Relationship (Type, Print)

Andrew Winters/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11505 Piney Lodge Rd. Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

03/01/07

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

MO1251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aplastic Anemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Cynthia M. Williams D.O.

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

2-27-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

K. H. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08038

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine

Howard

2. Date of Death

Month  
02Day  
28Year  
07

3. Time of Death

0930 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

214 10 7749

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

09 01 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

511 Buena Vista Avenue

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ernest H. Riggin

18. Mother's Name (First, Middle, Maiden Surname)

Nora Smullen

19a. Informant's Name/Relationship (Type, Print)

Linda White/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9936 Middle Mill Drive, Owings Mills, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Andrews Episcopal

Date

03/03/2007

20c. Location - City or Town, State

Princess Anne, MD

21. Signature of Funeral Service Licensee

M00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Ave., Princess Anne, MD 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital

2 ☒ Inpatient3 ☐ ER/Outpatient4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Conall, MD Coastal Hospice P.O. Box 1733 Salisbury MD 21802

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Heaven to go

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08039

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARY S. INNES</b>  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 7, 2007</b>  |   | 3. Time of Death<br><b>5:45 a<sup>M</sup></b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Laurelwood Nursing Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   | 4c. County of Death<br><b>Cecil</b>   |  |
| 5. Social Security Number<br><b>163-05-9962</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 19 1916</b>                       | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |
| Usual Residence of Decedent   |  |   |   |   |  |
| 10a. State<br><b>DE</b>   | 10b. County<br><b>New Castle</b>   | 10c. City, Town or Location<br><b>New Castle</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>418 Old Forge Rd.</b>  |  | 10f. Zip Code<br><b>19720</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Private College</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas D. Simpson</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeannette S. Albany</b> |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Gartside (daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22 Rambleton Rd. New Castle, DE. 19720</b>  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chester Rural Cem.</b>   |   | 20c. Location - City or Town, State<br><b>3/12/07 Chester, PA.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>James M. Brower Funeral Home</b><br><b>908 S. Providence Rd. Wallingford PA.</b>   |   | 19086   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>FAILURE TO THRIVE</b><br>a. Due to (or as a consequence of):<br><b>CAD</b><br>b. Due to (or as a consequence of):<br><b>CVA</b><br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>054073</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>08 MAR 07</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Arlon Stone, MD 817 Courthouse Cir New Castle DE 19720</b>   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 2007</b>   |  | 32. Registrar's Signature<br>  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08040

1- For State Registrar

Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician / Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Michael Wayne Imes</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 18 2007</b>  |  | 3. Time of Death<br><b>2:35P M</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince Georges</b>                            |  |
| Funeral Director   | 5. Social Security Number<br><b>233-78-4849</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 22, 1948</b>            |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Thurmont</b>                          |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>12027 Pennterra Manor Lane</b>   |  | 10f. Zip Code<br><b>21788</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>cable splicer</b>                 |  | 16b. Kind of Business/Industry<br><b>communication</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ralph Ernest Imes</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie June Smith</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan H. Imes/ wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12027 Pennterra Manor Lane Thurmont, MD 21788</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>   |  | 20c. Location - City or Town, State<br><b>2/25/2007 Sykesville, MD</b>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Catherine O. Hartzler</i>   |  |   |  | 22. Name and Address of Facility<br><b>Hartzler Funeral Home<br/>404 S. Main St. Woodsboro, MD 21798</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>septic shock</b><br>Due to (or as a consequence of):<br>b. <b>polymicrobial septicemia</b><br>Due to (or as a consequence of):<br>c. <b>pneumonia</b><br>Due to (or as a consequence of):<br>d. <b>ventilator dependent respiratory failure</b> |  |   |  |  |  |   |  |
|  | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  |   |  |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)  |   |  |   |  |  |  |   |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |   |  |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 28d. Describe how injury occurred  |   |  |   |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |   |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |   |  |  |  |   |  |
| 29c. License number<br><b>D27577</b>   |   |  |   |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/18/07</b>  |   |  |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ophnell Cumberbatch 3001 Hospital Drive Cheverly, MD 20785</b>  |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 26 2007</b>  |   |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
**Amend Item 27 per dr., 8865, 03/14/07 dmb**  
**Certificate of Death**

Reg. No.

1- For State Registrar

2007 08041

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State Registrar**

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Edward H. James</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>15</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>10:20 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>VA Maryland HealthCare System Perry Point</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cecil</b>   |  | 4c. County of Death<br><b>Buckingham PA</b>  |  |
| 5. Social Security Number<br><b>171-22-6071</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>79</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>8-21-27</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Buckingham PA</b>   |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>PA</b>  |  | 10b. County<br><b>Chester</b>   |  | 10c. City, Town or Location<br><b>47 West Locust St. Oxford</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>47 West Locust St.</b>  |  |   |  | 10f. Zip Code<br><b>19363</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administration</b>   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Calvin James</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Erwin</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Pauline James</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>47 West Locust St. Oxford, PA 19363</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evans Crematory</b>  |  | Date<br><b>Feb. 17, 07</b>   |  | 20c. Location - City or Town, State<br><b>Leola, PA 17540</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Edward L. Collins Funeral Home, Inc. 86 Pine St. Oxford, PA 19363</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Guillain-Barre Syndrome</b>  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Unknown</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>   |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>151094-1</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 15, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Melicia Santos, M.D., VA Maryland HealthCare System, Perry Point, MD 21902</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 27 2007</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08042

|  |  |   |  |  |  |  |   |   |  |
|--|--|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANITA CHRISTINA KREISEL</b>                               |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>6</b> Year <b>2007</b> |  | 3. Time of Death<br><b>10:20 PM</b>                     |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>               |  | 4c. County of Death<br><b>Harford</b>                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-80-2710</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>5/28/1922</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Forest Hill</b>       |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1808 Alpine Drive</b>   |  | 10f. Zip Code<br><b>21050</b>  |   | 10g. Citizen of What Country?<br><b>United States</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Wade</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anita Yewell</b>   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William L. Kreisel/Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1808 Alpine Drive Forest Hill, Md. 21050</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>  |  | Date<br><b>3/10/07</b>   |  | 20c. Location - City or Town, State<br><b>Hampstead, MD.</b>   |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Jarrettville, Maryland</b><br><b>E.G. Kurtz &amp; Son Funeral Home, P.A.</b>   |  |  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>coronary artery disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death          |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)         |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                     |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D32219</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 7, 2007</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David S. Drury 615 W. Maple Hall Bel Air MD 21014</b>   |  |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 2007</b>  |  | Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |   |   |  |

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar 2-28-07  
Amend #26 Per Phys. PCOR

## Certificate of Death

Reg. No. 2007 08043

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mahmuda Begum Khan

2. Date of Death

Month Day Year  
2-21-2007

3. Time of Death

10:00a<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

14003 Artic Ave

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

217-88-7459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
9-14-1940

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Springs

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 Fox Hall Ct.

10f. Zip Code

20906

10g. Citizen of What Country?

Pakistan

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Barkat Ali

18. Mother's Name (First, Middle, Maiden Surname)

Sakeena Begum

19a. Informant's Name/Relationship (Type, Print)

Jamil Khan - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3127 Hel Sel Dr., Silver Springs, Md. 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

George Wash. Cemet.

Date

2-22-07

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Universal II Mortuary Inc.  
411 Kennedy St., N.W., Wash, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic cholangiocarcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0064615

29d. Date signed (Month, Day, Year)

2/22/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, MD 1355 Piccard Dr. Rockville, MD

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08044

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Faye V. Keffer

2. Date of Death  
Month Day Year  
February 24, 20073. Time of Death  
0545 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

215-12-4471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 14, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2012 Suffolk Lane

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

James W. Allen

18. Mother's Name (First, Middle, Maiden Surname)

Myrtie Eckman

19a. Informant's Name/Relationship (Type, Print)

Clifford Keffer Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2012 Suffolk Lane Finksburg, MD 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sandy Mount Cemetery

Date

2/28/07

20c. Location - City or Town, State

Finksburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home & Chapel, PA  
412 Washington Rd., Westminster, MD 2115723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. END STAGE DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D35398

29d. Date signed (Month, Day, Year)

2-26-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flavio Kruter MD 555 South Center Street Westminster, MD 21157

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08045

1- For State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |                                |  |   |
|---|--|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vickie Lynn Linton</b>   |  |   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>21</b> Year <b>2007</b>   |                                | 3. Time of Death<br><b>4:00 P M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>5532 Bethel Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Woodbine</b>   |                                | 4c. County of Death<br><b>Carroll</b>  |   |
| 5. Social Security Number<br><b>219-70-9867</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Apr 13 1963</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
| Usual Residence of Decedent   |  |   |  |   |                                |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Woodbine</b>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>5532 Bethel Road</b>   |  |   |  | 10f. Zip Code<br><b>21797</b>   |                                | 10g. Citizen of What Country?<br><b>US</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |                                | 16b. Kind of Business/Industry<br><b>Her Home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas C. Wright Jr</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleanor Irene (Treasler) Myers</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>David Linton, Jr. Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5532 Bethel Road Woodbine, MD 21797</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pleasant Ridge Cem.</b>  |  | Date<br><b>Feb 26 2007</b>  |                                | 20c. Location - City or Town, State<br><b>Woodbine, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Home<br/>1212 W. Old Liberty Rd., Winfield, MD 21784</b>   |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Candace armstrong</b><br>Due to (or as a consequence of):<br><b>lung</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes mellitus</b><br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death<br><b>3 Years</b><br><b>&gt; 5 Years</b><br><b>&gt; 5 Years</b>  |                                |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>possible oral syndrome</b>   |  |   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                                |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D53705</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>02/23/07</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ABRAHAM MATTHEW MD 3125 Baltimore Blvd Pikesburg, MD 21042</b>   |  |   |  |   |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 26 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |                                |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, 26, per VERB, G865, 3/14/07, WS

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2007 08046

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maxine Lee

2. Date of Death

March 5, 2007 4:87P M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

218-34-1170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 24, 1936

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2012 RUXTON AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MENTAL HEALTH

16b. Kind of Business/Industry

SOCIAL WORKER

17. Father's Name (First, Middle, Last)

HAROLD MATTHEWS

18. Mother's Name (First, Middle, Maiden Surname)

ELOUISE CONAWAY LEE MATTHEWS

19a. Informant's Name/Relationship (Type, Print)

DOROTHY CURTIS (AUNT)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2012 RUXTON AVENUE BALTIMORE MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHURCH OF DELIVERANCE

Date

3/10/07

20c. Location - City or Town, State

LIVELY VIRGINIA

21. Signature of Funeral Service Licensee

B. O. Waddy

22. Name and Address of Facility

BERRY O. WADDY  
6784 MARY BALDWIN ROAD  
LANCASTER VA. 22503

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY EXERCERBATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. O. Waddy, MD

29c. License number

D0052950

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 W. Baltimore ST Baltimore, MD 21223

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

B. O. Waddy

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 21264

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar 3-2-07 AMEND #27. PERMITS OR State of Maryland Department of Health and Mental Hygiene 2007 08047  
 3-5-07 AMEND #27. PERMITS OR Certificate of Death Reg. No.

|  |  |  |   |   |  |   |   |
|--|--|--|---|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ciria Edith Gomez Lawrens</b>   |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>24</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>0844 M</b>             |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Chesley</b>  |  | 4c. County of Death<br><b>Prince George's</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-57-1213</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>40</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>May 1, 1966</b>                                   |
|  | 9. Birthplace (State or Foreign Country)<br><b>Honduras</b>  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Hyattsville</b>   |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6800 Highview Terrace #104</b>   |   | 10f. Zip Code<br><b>20782</b>  |   | 10g. Citizen of What Country?<br><b>Honduras</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Honduran</b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Person</b>                  |   | 16b. Kind of Business/Industry<br><b>Private</b>   |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Reynaldo Gomez</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Inez Lawrens</b>  |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Daisy Gomez (Sister)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5926 Brin Mawd, College Park MD 20740</b> |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hall Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>El Progreso, Yoro, Honduras</b>  |   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Rendon/Hale Funeral Home</b><br><b>9013 Annapolis Road, Lanham MD 20706</b>                                |   |  |   |   |
|  | 23a. Part I. Enter the disease (or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebral edema</b><br>Due to (or as a consequence of):<br><b>subdural hematoma</b><br>Due to (or as a consequence of):<br><b>pedestrian Struck</b><br>Due to (or as a consequence of): |  |   |   |  |   |   |
|  | 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown   |  |   |   |  |   |   |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |  |   |   |  |   |   |
| Physician<br>/Medical<br>Examiner  | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |   |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>right tibial plateau Fracture</b><br><b>pulmonary contusion</b>   |  |   |   |  |   |   |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |   |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |   |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |   |   |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |   |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)<br><b>February 18, 2007</b>   |   | 28b. Time of injury<br><b>2205 M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 28d. Describe how injury occurred<br><b>Pedestrian Struck while crossing street</b>  |  | 28e. Place of Injury - At home, arm, street, factory, office building, etc. (Specify)<br><b>street</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore Avenue at Guilford Rd College Park Md</b>   |   |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>16055937</b> |   | 29d. Date signed (Month, Day, Year)<br><b>2/24/07</b>   |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Will Ann Boyce PG Hospital 3001 Hospital Drive, Chesley, Maryland</b> |  |  |   |   |  |   |   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |   |

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08048

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADELE MATTHEWS

2. Date of Death

MARCH 7, 2007

3. Time of Death

7:34 p.m.

4a. Facility Name (If not institution, give street and number)

31857 Griffith Dr.

4b. City, Town, or Location of Death

Galena

4c. County of Death

Kent

5. Social Security Number

150-20-2383

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov 11 1917

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Kent

10c. City, Town or Location

Galena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

31857 Griffith Dr.

10f. Zip Code

21635

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Catering Service

17. Father's Name (First, Middle, Last)

Peter Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Eva Pelutis

19a. Informant's Name/Relationship (Type, Print)

Joyce Flach (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31857 Griffith Dr. Galena, MD. 21635

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hollywood Cemetery 3/13/07

Date

20c. Location - City or Town, State

Union, NJ.

21. Signature of Funeral Service Licensee

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen L. Schaeche  
118 West Cross St. Galena, MD. 21635

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multi infarct Dementia  
Due to (or as a consequence of):  
Cerebral Vascular Accident

Approximate Interval Between Onset and Death

&gt;5y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
Atrial Fibrillation

&gt;5y

&gt;5y

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D588241

29d. Date signed (Month, Day, Year)

3/9/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Donaher, M.D. 119 C. North Main St. Galena, MD. 21635

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

Karen L. Spivey

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, #

3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08049

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vernon O'Neill Moore</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>5</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>3:40 A<sup>M</sup></b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>N M S Health Care</b>   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>215-14-1585</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>March 6, 1923</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>14107 Marsh Pike</b>  |  | 10f. Zip Code<br><b>21742</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1942</b><br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Attendent</b>   |  | 16b. Kind of Business/Industry<br><b>Gas Station</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William O. Moore</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura (Unknown) Moore</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edythe L. Moore/Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14107 Marsh Pike, Hagerstown, MD 21742</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Hagerstown, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>S. Mark Sings</b>  |  | 22. Name and Address of Facility <b>Rest Haven Funeral Chapel</b><br><b>1601 Pennsylvania Ave., Hagerstown, MD 21742</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. <b>Chronic obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>c. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  | Approximate Interval Between Onset and Death<br><b>15y</b><br><b>25y</b><br><b>15y</b>   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>1252523</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>03-05-2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Khalid Waseem MD 1126 Opal Court, Hagerstown, MD 21740</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year) <b>MAR 14 2007</b> 32. Registrar's Signature <b>[Signature]</b>  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerDivision or Vital Records, P.O. Box 68760, W  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08050

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

George Thomas McGuckian

2. Date of Death

Month Day Year  
02 25 07

3. Time of Death

1011 M

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

213-30-1674

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 7, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

28483 Pinehurst Circle

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates: 1946-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

George Charles McGuckian

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elsie Leitch

19a. Informant's Name/Relationship (Type, Print)

Thomas G. McGuckian/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5704 Harmony Road Preston, Maryland 21655

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory

Date

2/28/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael J. Taylor

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

3 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending investigation

2 Accident

3 Suicide

4 Homicide

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis DeShields

29c. License number

D0053110

29d. Date signed (Month, Day, Year)

February 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Dennis DeShields 219 S. Washington Street Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 27 2007

Registrar's Signature

Dennis DeShields

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08051

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Margaret L. Moore

2. Date of Death

Month 22, Day 2007

3. Time of Death

5:12P M

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral Director

5. Social Security Number

135-18-8476

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) July 10, 1920

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701- Veirs Drive

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Bernard Love

18. Mother's Name (First, Middle, Maiden Surname)

Eunice Craig

19a. Informant's Name/Relationship (Type, Print)

Ronald Moore - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18319 Honey Locust Circle, Gaithersburg, Md.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory-2/23/07-Alexandria, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*W. H. Thompson*

22. Name and Address of Facility

2222-Wisconsin Ave., NW  
Hysong Co., Inc. Washington, DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *pelvic tumor*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *renal failure*  
Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*anemia*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Charles W. Kares*

29c. License number

D21726

29d. Date signed (Month, Day, Year)

February 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHARLES W. KARES - 9701-VEIRS DR., ROCKVILLE, MD.

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

*James B. Smith*

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



**VOID**

**CERTIFICATE #**

2007- 08052

**SEE**

**CERTIFICATE #**

2007- 07302

Deceased Name - Lewis Roger Moore

6-1-07

Timiki Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08053

1- For  
State  
Registrar

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles D. Metz III</b>  |   | 2. Date of Death<br>Month Day Year<br><b>February 20, 2007</b>  |   | 3. Time of Death<br><b>8:51 A M</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-62-5184</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 17, 1948</b>     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent   |   |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Bel Air</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>717 Country Village Drive</b>  |   | 10f. Zip Code<br><b>21014</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>            |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>dentist</b>   |   | 16b. Kind of Business/Industry<br><b>dental healthcare</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Daniel Metz Jr.</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eileen E. Myers</b>   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Scott M. Metz/ son</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 Kirsten Ct. Parkton, MD 21120</b>         |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pipe Creek Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>nr. Linwood, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Catherine O. Wagner</b>   |   | 22. Name and Address of Facility<br><b>Hartzler Funeral Home<br/>11802 Liberty Rd. Libertytown, MD 21762</b>                                      |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                                 |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>RES-006</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 20, 2007</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Danesh Mazloomdoost 600 North Wolfe St Baltimore, Maryland 21287</b>   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 26 2007</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

WJL  
25

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08054

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Richard Myers

2. Date of Death  
Month Day Year  
February 25, 2007 6:27 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

234-32-8838

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

August 17, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Colton's Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20560 Richard Wilson Lane

10f. Zip Code

20626

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Coal Miner

16b. Kind of Business/Industry

Coal Mining

17. Father's Name (First, Middle, Last)

Richard Jackson Myers

18. Mother's Name (First, Middle, Maiden Surname)

Hester Pauline Deavers

19a. Informant's Name/Relationship (Type, Print)

Mary Kay Myers/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1 Colton's Point, MD 20626

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Valley Cem. 3/1/2007

Date

20c. Location - City or Town, State

Oakland, Maryland

21. Signature of Funeral Service Licensee

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

211 St. Mary's Ave. La Plata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADVANCED CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. ACUTE BRONCHIAL FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

x yrs  
x wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George H. Warden M.D. WARDEN, MD 20603

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Brenn K. Spivey

State Registrar

Leo Richard Myers  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08055

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte I. Mathis

2. Date of Death  
Month Day Year

February 23, 2007

3. Time of Death

8:35 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

303 Canberra Court

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

215-24-7823

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth  
(Month, Day, Year)

Sept. 29, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

303 Canberra Court

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Vernon Smith

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Black

19a. Informant's Name/Relationship (Type, Print)

Becky Lawson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Caberra Court, Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stauffer Crematory

Date

3/1/2007

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Sharon Camille Cline

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CHF

Due to (or as a consequence of):

Atherosclerotic Heart Disease

Due to (or as a consequence of):

Type II DM

Due to (or as a consequence of):

Pulmonary Fibrosis

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

G. Segal, M.D.

29c. License number

20054940

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AZEB TESFAILOS MP 110 Baughmans Lane Frederick, MD 21702

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Kerem K. Aydin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08056

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARION E. MUNN

2. Date of Death  
Month Day Year  
FEBRUARY 16 20073. Time of Death  
7:00PM M

4a. Facility Name (If not institution, give street and number)

WILLIAM HILL MANOR

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director5. Social Security Number  
018-14-09166. Sex  
1 ☐ M 2 ☒ F7. Age (in yrs. last birthday)  
85 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
SEPT. 6, 19219. Birthplace (State or Foreign  
Country)  
MASS.

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26949 MILES RIVER ROAD

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM J. CLARKE

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE MOXLEY

19a. Informant's Name/Relationship (Type, Print)

WILLIAM H. MUNN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26949 MILES RIVER ROAD, EASTON, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLENWOOD CEMETERY

Date

2/21/2007

20c. Location - City or Town, State

EVERETT, MASS.

21. Signature of Funeral Service Licensee

JOHN R. MERCIER

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

12 hrs

10 yrs

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

William H. Wood, Jr. MD

29c. License number

1508715

29d. Date signed (Month, Day, Year)

2/17/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD, JR., M.D., 501 DUTCHMANS LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 22 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08057

1- For State Registrar

Physician / Medical Examiner

Funeral Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elmer T. Myers</b>   |  | 2. Date of Death<br>Month: <b>02</b> Day: <b>23</b> Year: <b>2007</b>   |  | 3. Time of Death<br><b>4:40a<sup>M</sup></b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>605 Rigby St.</b>  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>  |  | 4c. County of Death<br><b>Dorchester</b>   |  |
| 5. Social Security Number<br><b>219-36-7088</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>11/21/1911</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>Westminister MD</b> |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Dorchester</b>   | 10c. City, Town or Location<br><b>Cambridge</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>605 Rigby St.</b>  |  | 10f. Zip Code<br><b>21613</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1/1/43 - 2/12/46</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator</b>  |  | 16b. Kind of Business/Industry<br><b>Dorchester County School</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elmer Ellsworth Myers</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harvine Charms</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alda W. Myers / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>605 Rigby St. Cambridge, MD 21613</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Md Veterans Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/1/2007 Hurlock, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home 21601 426 E. Dover St. Easton, MD</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Advanced Demented State</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Dementia</b> |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>10 yrs.</b><br><b>10 yrs.</b>  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month: Day: Year:   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes <input checked="" type="checkbox"/> No   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D26388</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 1, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J Pridemore MD 302 Collins Ave Hurlock MD 21643</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend line 23e per phy  
 State  
 Registrar

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08058

3/02/07 dlw

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEWIS

NORWOOD

2. Date of Death

Month

Day

Year

3. Time of Death

2355 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

213-32-0244

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 25, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 Tarragon Lane

10f. Zip Code

21037

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married3 ☐ Widowed4 ☐ Divorced2 ☒ Married

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

Year or Dates: 1955-1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive of Engineering Panel

16b. Kind of Business/Industry

National Security

17. Father's Name (First, Middle, Last)

William M. Norwood

18. Mother's Name (First, Middle, Maiden Surname)

Anita Howard

19a. Informant's Name/Relationship (Type, Print)

Estelle D. Norwood / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Tarragon Lane Edgewater, MD 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Vet. Cem.

Date

3/5/2007

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

Michael J. Taylor

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Taylor

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

Feb 26, 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Taylor

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

Rene B. Spivey

21401

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1-

For  
State  
Registrar

Amend #3 Per PHF 6865 3/30/07 JH

Certificate of Death

Reg. No. 2007 08059

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dolores K. Nicholson</b>   |  | 2. Date of Death<br>Month <b>02</b> Day <b>20</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>2:10AM</b><br><b>6:15A</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>South River Health and Rehab</b>   |  | 4b. City, Town, or Location of Death<br><b>Edgewater</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>220-38-1299</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>79</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>10/02/1927</b> | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C</b>  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Churchton</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1216 Ellicott Ave.</b>   |  | 10f. Zip Code<br><b>20733</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>02</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>   |  | 16b. Kind of Business/Industry<br><b>Retail</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Carl Ritchie</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha L. Ryon</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet Hough Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17383 Hardy Road Mt. Airy, MD 21771</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Christ Church</b>  |  | 20c. Location - City or Town, State<br><b>West River, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A. 12 Ridgely Ave<br/>Annapolis, MD 21401</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arrive Fibrillation</b><br><b>Hypertension</b>  |  |   |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D57313</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/27/07</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MITUL DAVE 827 Linden Ave Baltimore 21201</b>  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 27 2007</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

attend line 18 per fd  
aaco hlth dept 2/27/07 dlw  
1- State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2007 00060

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Rose Anna Narmon</i>   |  | 2. Date of Death<br>Month <i>2</i> Day <i>23</i> Year <i>07</i>   |  | 3. Time of Death<br><i>0615</i> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Anne Arundel Medical Center</i>  |  | 4b. City, Town, or Location of Death<br><i>Annapolis</i>  |  | 4c. County of Death<br><i>Anne Arundel</i>  |  |
| 5. Social Security Number<br><i>513-16-5381</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>81</i> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><i>Jan 13 1926</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>Kansas</i>   |  |   |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Anne Arundel</i>  |  | 10c. City, Town or Location<br><i>Annapolis</i>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><i>930 Bay Forest Ct. Apt 310</i>   |  | 10f. Zip Code<br><i>21403</i>   |  |
| 10g. Citizen of What Country?<br><i>USA</i>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>0</i>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>   |  | 16b. Kind of Business/Industry<br><i>None</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Oscar Crosswright</i>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Clady G. Gladys Wrothwell</i>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Joseph E. Norman (Husband)</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>930 Bay Forest Ct. Apt 310 Annapolis, Md. 21403</i>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of Cemetery, Crematory or other place)<br><i>Memorial Park</i>  |  | 20c. Location - City or Town, State<br><i>3-1-07 Annapolis, Md.</i>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Larry S. Reese M06483</i>   |  | 22. Name and Address of Facility<br><i>Wm. Reese &amp; Sons Mortuary, P.A.<br/>821 West St. Annapolis, Md. 21401</i>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Renal failure</i><br>Due to (or as a consequence of):<br><i>Diabetes</i><br>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Hypertension</i><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><i>year</i><br><i>year</i><br><i>year</i>   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown  |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>CITK</i><br><i>is chemie cardiology pathy</i>  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Michael J. Lafenta</i>  |  |
| 29c. License number<br><i>0 21438</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>2. 23. 07</i>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>MICHAEL J. Lafenta MD 445 DEFENSE HIGHWAY ANNAPOLIS MD</i>   |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 27 2007</i>   |  | Registrar's Signature<br><i>Rose B. Spivey</i>  |  | 21401   |  |

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State of Maryland / Department of Health and Mental Hygiene

2007 08061

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Louis Plumer

2. Date of Death

March 07 2007

3. Time of Death

11:00PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1924 Glen Cove Road

4b. City, Town, or Location of Death

Darlington

4c. County of Death

Harford

5. Social Security Number

218-32-8753

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

7/24/1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Darlington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1924 Glen Cove Road

10f. Zip Code

21034

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Supervisor

16b. Kind of Business/Industry

Construction Equip.

17. Father's Name (First, Middle, Last)

Henry John Plumer, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Mary Milchling

19a. Informant's Name/Relationship (Type, Print)

Elaine Van Hart/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 Brer Rabbit Road, Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Cem.

Date

3/12/2007

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*Jeffrey P. Lovelidge*

22. Name and Address of Facility

Harkins Funeral Home, Inc., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic renal failure

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

10 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic lymphocytic leukemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Prashant Shukla, MD*

29c. License number

000042050

29d. Date signed (Month, Day, Year)

3/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prashant Shukla, MD 15 South Park Street #400 Aberdeen MD 21001

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

*John H. Sparks*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21215

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08062

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

441

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMES MORRIS PADGETT</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>6</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>11:15 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9833 MEADOWVIEW DRIVE</b>   |  | 4b. City, Town, or Location of Death<br><b>NEWBURG</b>   |  | 4c. County of Death<br><b>CHARLES</b>  |  |
| 5. Social Security Number<br><b>577-58-7031</b>  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 1, 1946</b> |  | 9. Birthplace (State or Foreign Country)<br><b>WASH., DC</b> |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>CHARLES</b>  |  | 10c. City, Town or Location<br><b>NEWBURG</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>9833 MEADOWVIEW DRIVE</b>   |  | 10f. Zip Code<br><b>20664</b>  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1966-1969</b>   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TELECOMMUNICATIONS SPECIALIST AT &amp; T</b>   |  | 16b. Kind of Business/Industry   |  | 17. Father's Name (First, Middle, Last)<br><b>JAMES A. PADGETT</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CORDELIA CURTIS</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY PADGETT-WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9833 MEADOWVIEW DRIVE, NEWBURG, MD 20664</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEM. GDNS.</b>  |  | 20c. Location - City or Town, State<br><b>3-10-07 WALDORF, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M0047</b>  |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.</b><br><b>LA PLATA, MARYLAND 20646</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br><br>b. <b>MORBID OBESITY</b><br>Due to (or as a consequence of):<br><br>c. <b>HYPVENTILATION SYNDROME</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><b>x-years</b><br><b>x-years</b> |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br><br><b>George H. Watkinson M.D.</b>   |  | 29c. License number<br><b>D20629</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/7/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George H. Watkinson M.D. Waldorf, Md 20603</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 2007</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar 2-28-07Amd #26, Per Phys. RGCcr

Certificate of Death

Reg. No. 2007 00063

|  |  |  |   |                               |   |  |   |  |  |  |  |  |
|--|--|--|---|-------------------------------|---|--|---|--|--|--|--|--|
| Physician / Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Donald Edward Powell   |  |   |                               | 2. Date of Death<br>February 22, 2007   |  |   |  | 3. Time of Death<br>11:30 A M  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Mrs. Philippines Senior Citizen Home   |  |   |                               | 4b. City, Town, or Location of Death<br>Ft. Washington  |  |   |  | 4c. County of Death<br>Prince George's   |  |  |  |
| Funeral Director   | 5. Social Security Number<br>230-46-3467   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>67 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 8, 1940                   |  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  |  |  |
|  | Usual Residence of Decedent  |  |   |                               |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's  |                               | 10c. City, Town or Location<br>Fort Washington  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|  | 10e. Street and Number<br>6824 Bock Road Apt. 411  |  |   |                               | 10f. Zip Code<br>20744  |  |   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+)   |  |   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Taxi Driver  |  |   |  | 16b. Kind of Business/Industry<br>Livery   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Bernard Powell  |  |   |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise Whitehead |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Fay Courtney / Sister  |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7608 Locust Ln., Ft. Washington, MD 20744  |  |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Kalas Crematory   |  |   |  | Date<br>2/24/2007  |  | 20c. Location - City or Town, State<br>Edgewater, MD |  |
|  | 21. Signature of Funeral Service Licensed<br><i>George P. Kalas III</i>  |  |   |                               | 22. Name and Address of Facility<br>George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd., Oxon Hill, MD 20745   |  |   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>prostate Cancer</i><br>Due to (or as a consequence of):<br>b. <i>Cerebral Vascular Disease</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |  |   |                               |   |  |   |  |  |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown   |  |   |                               |   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)  |  |   |                               | 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                               |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                    |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |                               |   |  |   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                               |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                               |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>William T. Tanner</i>  |  |  |   | 29c. License number<br>D35206 |   |  |   | 29d. Date signed (Month, Day, Year)<br>February 22, 2007 |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William T. Tanner, M.D. 11701 Livingston Rd., Ft. Washington, MD 20744   |  |  |   |                               |   |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>FEB 28 2007   |  |   |                               | 32. Registrar's Signature<br><i>James A. Spade</i>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00064

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carole Ann Pfeifer

2. Date of Death  
Month Day Year  
February 23, 20073. Time of Death  
12:00p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11060 Weymouth Ct.

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

5. Social Security Number

216-70-9574

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 20, 1938

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11060 Weymouth Ct.

10f. Zip Code

20603

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Greeter

16b. Kind of Business/Industry

Store

17. Father's Name (First, Middle, Last)

William Reedy Bartley

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Elizabeth Hawkins

19a. Informant's Name/Relationship (Type, Print)

Daughter  
Pamela Larrimer-Simmons

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2116 Briarwood Dr., Waldorf, Md. 20601

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

March 1, 2007  
Washington National Cem.

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A. 20640  
4270 Hawthorne Rd., Indian Head, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42509

29d. Date signed (Month, Day, Year)

02/26/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEINORZ SMITH 12070 OLD LINE CTR #100 WILDFORD, MA, 21037

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

K. H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08065

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Padgett

2. Date of Death  
Month Day Year  
February 24, 2007  
3. Time of Death  
8:00 a.m.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11 Rosewood Court

4b. City, Town, or Location of Death

Woodsboro

4c. County of Death

Frederick

5. Social Security Number

549-05-4130

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

December 18, 1916 California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Woodsboro

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11 Rosewood Court

10f. Zip Code

21798

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Nassau County Government

17. Father's Name (First, Middle, Last)

Edward H. Sanderson

18. Mother's Name (First, Middle, Maiden Surname)

Della Nelson

19a. Informant's Name/Relationship (Type, Print)

Katharine Powell - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2826 Wildwood Court, Walkersville, Maryland 21793

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glade Cemetery

Date

3-2-2007

20c. Location - City or Town, State

Walkersville, Maryland

21. Signature of Funeral Service Licensee

Sharon Camille Cline

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):b. Decubitus Ulcers  
Due to (or as a consequence of):c. Peripheral Vascular Disease  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2-3 days

weeks

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

Cerebrovascular Accident

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Convey, M.D.

29c. License number

D20395

29d. Date signed (Month, Day, Year)

Feb 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Convey, M.D. 195 Thomas Johnson Drive, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Brian H. Spauld

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08066

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mark E. Redding</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 20 2007</b>  |  | 3. Time of Death<br><b>8:45P<sup>M</sup></b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Dove House Hospice</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>180-22-3928</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 16, 1930</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  | 10a. State<br><b>PA</b>  |  | 10b. County<br><b>Adams</b>  |  | 10c. City, Town or Location<br><b>Hanover</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>5 Cherry Valley Road</b>  |  | 10f. Zip Code<br><b>17331</b>  |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1950-51</b> |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                          |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Auto Manuals</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Sylvester Redding</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Eckenrode</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Redding - wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 Cherry Valley Rd. Hanover, PA 17331</b>  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Aloysius Cemetery</b>   |  |  |  |
|  | 20c. Location - City or Town, State<br><b>Littlestown, PA</b>   |  |  |  | 21. Signature of Funeral Service Licensee<br><b>Richard Little Jr.</b>   |  |  |  |
|  | 22. Name and Address of Facility<br><b>Little's FH 34 Maple Ave. Littlestown, PA 17340</b>  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. directly route aneurysm</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |
| 28d. Describe how injury occurred  |   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Robert R. Remy</b>   |   |  |  | 29c. License number<br><b>00064597</b>   |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/21/07</b>  |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert L. Rice 555 South Center Street Westminster, MD 21157</b>  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 26 2007</b>  |   |  |  | 32. Registrar's Signature<br><b>Heaven to go</b>   |  |  |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

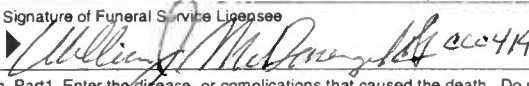
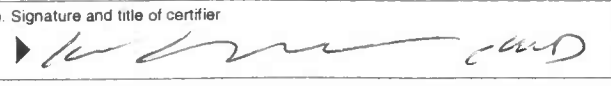
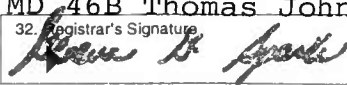
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08067

|                                     |   |  |   |  |  |  |  |  |
|-------------------------------------|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Lou Russell</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 22 2007</b>  |  | 3. Time of Death<br>M<br><b>6:10PM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Kline Hospice House</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Mount Airy</b>  |  | 4c. County of Death<br><b>Frederick</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>228-54-4461</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 16, 1931</b>                           |  |
|                                     | 9. Birthplace (State or Foreign Country)<br><b>VA</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Brunswick</b>                                      |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|                                     | 10e. Street and Number<br><b>1114 Second Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21716</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Elbert Shumaker</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leila N/A</b>  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elmer Russell - Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1114 Second Avenue, Brunswick, MD 21716</b>  |  |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lovettville Union</b>  |  | Date<br><b>Feb 28</b>  |  | 20c. Location - City or Town, State<br><b>Lovettville, VA</b>                        |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Loudoun Funeral Chapels</b><br><b>158 Catoctin Cr. SE, Leesburg, VA 20175</b>  |  |  |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><b>Advanced Ovarian Cancer</b>  |  |   |  |  |  |  |  |
|                                     | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23c. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |  |
|                                     | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DY1866</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 2007</b>  |  |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Kanan Hudhud, MD 46B Thomas Johnson Drive, Frederick, MD 21702</b>   |  |   |  |  |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08068

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |                                 |  |  |   |  |
|--|---|---|--|---|--|---------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE AUGUSTUS RIGHTER</b>                          |   |  |   | 2. Date of Death<br>Month Day Year<br><b>FEB 28 2007</b>   |                                 |  |  | 3. Time of Death<br><b>7:20 AM</b>                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WESTMINSTER NURSING CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b> |                                 |  |  | 4c. County of Death<br><b>CARROLL</b>                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-20-2125</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.           |                                 | 8. Date of Birth (Month, Day, Year)<br><b>NOV 1 1924</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|  | Usual Residence of Decedent   |   |  |   |  |                                 |  |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>BOYDS</b>   |  |                                 |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>22930 SHILOH CHURCH ROAD</b>  |   |   |  | 10f. Zip Code<br><b>20841</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AUTO MECHANIC</b>   |  |                                 |  | 16b. Kind of Business/Industry<br><b>AUTO</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>AUGUSTUS REINIER RIGHTER</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL MILLS</b>   |  |                                 |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET RIGHTER/SPOUSE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22930 SHILOH CHURCH RD., BOYDS, MD 20841</b>  |  |                                 |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>STAUFFER CREMATORY</b>   |  | Date<br><b>3/1/07</b>           |  | 20c. Location - City or Town, State<br><b>FREDERICK, MD</b>                                    |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>HILTON FUNERAL HOME<br/>P.O. BOX 86, BARNESVILLE, MD 20838</b>   |  |                                 |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular accident</b><br>a. Due to (or as a consequence of):<br>b. <b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>10 yrs</b> |   |   |  |   |  |                                 |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                                 |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |                                 |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |  |                                 |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                 |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
|  |   |   |  | 28d. Describe how injury occurred   |  |                                 |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |   |  |
|  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |                                 |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D25443</b>  |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/2007</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John W. Middleton MD 688 Poole Rd, Westminster, MD 21157</b>  |   |   |  |   |  |                                 |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |   |   |  | 32. Registrar's Signature<br>   |  |                                 |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08069

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Gary Richard ROWE

2. Date of Death

Month Day Year  
March 7, 2007

3. Time of Death

0532 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

213-42-1553

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Dec. 10, 1941

9. Birthplace (State or Foreign Country)

W. Va.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 E. Lee Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

painter

16b. Kind of Business/Industry

city of Hagerstown

17. Father's Name (First, Middle, Last)

Richard Rowe

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Fuss

19a. Informant's Name/Relationship (Type, Print)

Virginia L. Rowe - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 E. Lee St., Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park

Date

3/10/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, PII, 27, per ME, g865, 3/23/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic alcohol abuse

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2007

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 06070

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID CHANG - KYUN SHIN</b>   |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 27, 2007</b>  |   | 3. Time of Death<br><b>4A M</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>9702 WASHINGTONIAN BLVD</b>   |   | 4b. City, Town, or Location of Death<br><b>GAITHERSBURG</b>   |   | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>229 98 0935</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 1, 1936</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>S. KOREA</b>   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>GAITHERSBURG</b>   |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |
|  | 10e. Street and Number<br><b>9702 WASHINGTONIAN BLVD</b>   |   | 10f. Zip Code<br><b>20878</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>ASIAN</b>  |   |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GOLF INSTRUCTOR</b>               |   | 16b. Kind of Business/Industry<br><b>PRIVATE</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>GAP GIL SHIN</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOL DOL LEE</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MICHAEL SHIN/SON</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14106 BLUE ASH WAY, ROCKVILLE MD 20850</b>    |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN</b>   |   | Date<br><b>3/1/07</b>  |
|  | 20c. Location - City or Town, State<br><b>SILVER SPRING MD</b>   |   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>CHARLES HINDS FUNERAL SERV<br/>12303 KAYAK DR. UPPER MARLBORO MD 20772</b> |   |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypertension</b><br><b>Dyslipidemia</b>   |   |   |   | Approximate Interval Between Onset and Death   |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |   |   |   | 23d. Date of delivery<br>Month Day Year  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D13621</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 1, 2007</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BOO K. KIM MD 8921 Shady Grove Ct, Gaithersburg, Md 20877</b> |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  | 32. Registrar's Signature<br>   |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

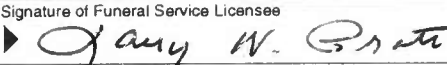
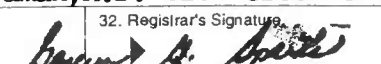
State of Maryland / Department of Health and Mental Hygiene

2007 08071

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Willa Ruth Smith</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 23, 2007</b>   |  | 3. Time of Death<br><b>4:25 P. M</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-36-2969</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>8/13/36</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>College Pk., Md.</b>  |   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>P.G.</b>   |  | 10c. City, Town or Location<br><b>College Park</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>8124 48th Avenue</b>   |  | 10f. Zip Code<br><b>20740</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>College</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietician</b>   |  | 16b. Kind of Business/Industry<br><b>Univ. Of Maryland</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Smith</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Willa Mae Potts</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ivy G. Briscoe/Daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1666 Willowood Ct., Cheverly, Maryland 20785</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queen's Chapel U.M.C. Cem.</b>   |  | Date<br><b>3/2/07</b>  |  | 20c. Location - City or Town, State<br><b>Beltsville, Md.</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Washington, D.C. 20019</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D41715</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/24/07</b>                        |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chitra Venkatraman, M.D. 6201 Greenbelt Rd. # U#3, College Park, Md. 20740</b>  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Amended Item 5 per F.D. 03/07/2007 Carroll County, wjl**  
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2007 08072

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Gerardo Gonzalez Serrano

2. Date of Death  
Month Day Year  
March 2, 20073. Time of Death  
0607 hrs

4a. Facility Name (if not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

Unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Apr. 24, 1959

9. Birthplace (State or Foreign Country)

Costa Rica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Keymar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12017 Legore Bridge Rd.

10f. Zip Code

21757

10g. Citizen of What Country?

Costa Rica

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No specify: Costa Rican

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

mechanic/ operator

16b. Kind of Business/Industry

dairy farm

17. Father's Name (First, Middle, Last)

~~Israel Castillo~~

unk.

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Gonzalez

19a. Informant's Name/Relationship (Type, Print)

Ines Vargas/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12017 Legore Bridge Rd. Keymar, MD 21757

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation

Date

3/6/2007

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

*Catherine O. Harbler*

22. Name and Address of Facility

Hartzler Funeral Home

404 S. Main St. Woodsboro, MD 21798

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☒ AMENDED #23a, 27, per ME, g865, 3/23/07 TT #1, per ME, 17, per FH

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Zabiullah Ali*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 3, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's Signature

*Geraldo Gonzalez*Physician/  
Medical ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08073

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hildegard Paula Solimando

2. Date of Death  
MonthDay Year  
February 22, 2007

3. Time of Death

0852 M

4a. Facility Name (If not institution, give street and number)

875 Snowfall Way

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-28-7293

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Apr 15, 1924

9. Birthplace (State or Foreign  
Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

875 Snowfall Way

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Karl Nesch

18. Mother's Name (First, Middle, Maiden Sumame)

Bertha (unknown)

19a. Informant's Name/Relationship (Type, Print)

Kim B. Dulik Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1652 Benson Rd. Westminster, MD 21158

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremation Inc

Date

2/23/07

20c. Location - City or Town, State

Hamstead, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home & Chapel, PA  
412 Washington Rd. Westminster, MD 2115723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Alzheimer's Disease*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Arteriosclerotic Vascular Disease*

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death10 yrs  
25y

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D25-443

29d. Date signed (Month/Day, Year)

2/22/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W. Middleton MD 688 Peck Rd, Westminster MD 21157

31. Date filed (Month, Day, Year)

FEB 26 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-328-2028.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitWJL  
20

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08074

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

David Edwin Syor

2. Date of Death

Month 2 Day 23 Year 07

3. Time of Death

1 35 P M

4a. Facility Name (If not institution, give street and number)

Dove House Carroll Hospice

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral Director

5. Social Security Number

218-58-5633

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov 23, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

54 Liberty Street, apt 2

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seaman

16b. Kind of Business/industry

Merchant Marines

17. Father's Name (First, Middle, Last)

Andrew Louis Syor

18. Mother's Name (First, Middle, Maiden Surname)

Myrtie Marie Bolen

19a. Informant's Name/Relationship (Type, Print)

Judith A. Streib, sister

19b. Address (Street, City, State, Zip Code)

920 Arnold Road, Westminster, MD 21157  
495 Tremont Drive, apt 8, Westminster, MD 21157

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

South Carroll Crematory

Date

02/24/2007

20c. Location - City or Town, State

Winfield, MD

21. Signature of Funeral Service Licensee

M01191

22. Name and Address of Facility

Myers-Durboraw Funeral Home  
91 Willis Street, Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxemia

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person completed cause of death (Item 3a) (Type, Print)

VINCENT J. FLOCCO JR

447 EAST MAIN ST.  
WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

FEB 26 2007

32. Registrar's Signature

W-JL 5

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08075

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Arnold Schein</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 27, 2007</b>   |   | 3. Time of Death<br><b>10:00 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sunrise Retirement Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |   | 4c. County of Death<br><b>Frederick</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>072-14-5087</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>April 3, 1923</b>     |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>  |   | 10c. City, Town or Location<br><b>Mount Airy</b>  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |
|   | 10e. Street and Number<br><b>6290 Twin Ponds Lane</b>  |  | 10f. Zip Code<br><b>21771</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:      |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Agent/ Salesman</b>  |   | 16b. Kind of Business/Industry<br><b>Insurance</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Roger J. Schein</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Unknown</b>  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul Schein / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6290 Twin Ponds Lane Mt. Airy, Maryland 21771</b>  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Gardens</b>  |   | 20c. Location - City or Town, State<br><b>Olney, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes, P.A.<br/>8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771</b>   |   |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Advance Dementia Frontal Lobe</b><br>Due to (or as a consequence of):<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><b>Hyperlipidemia</b> |  |  |   | Approximate Interval Between Onset and Death<br><b>Day</b><br><b>Years</b><br><b>Years</b><br><b>Years</b>  |
|   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) |
|   | 23d. Date of delivery<br>Month Day Year  |  |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroid, Diabetes,</b><br><b>Renal Insufficiency, Hypoalbumun</b>   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Assisted Living</b> |   |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D54749</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 2007</b> |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland 21701</b> |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | 32. Registrar's Signature<br> |  |   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08076

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Scott

2. Date of Death

Month Day Year  
February 23, 2007

3. Time of Death

8:15 P. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1000 Heather Ridge

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

579-26-2875

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 15, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1000 Heather Ridge

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic worker

16b. Kind of Business/Industry

Cleaning

17. Father's Name (First, Middle, Last)

Charles Marshall Smallwood

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae Weedon

19a. Informant's Name/Relationship (Type, Print)

Constance Whims - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 Heather Ridge, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fairview Cemetery

Date

3-2-2007

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

*Sharon Camille Cline*

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Pancreatic Cancer

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death Check only one

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*, MD

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

February 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhud, MD 468 Thomas Johnson Drive Frederick MD 21702

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08077

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Edwin B. Sinclair

2. Date of Death

Month 3

Day 1

Year 2007

3. Time of Death

2005 M

4a. Facility Name (If not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

212-28-8833

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

08-21-1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12531 Palmetto Church Road

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Man

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Lloyd Barton Sinclair

18. Mother's Name (First, Middle, Maiden Surname)

Grace Amelia Royer

19a. Informant's Name/Relationship (Type, Print)

Dorothy Ruth Sinclair/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12531 Palmetto Church Road, Princess Anne, MD 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sinclair Family Cem.

Date

03/04/2007

20c. Location - City or Town, State

Princess Anne, MD

21. Signature of Funeral Service Licensee

[Signature]

M00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Ave., Princess Anne, MD 21853

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26278

29d. Date signed (Month, Day, Year)

3-2-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David E. Coxall, MD Coastal Hospice PO Box 1733 Salisbury MD 21802

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No:

2007 08078

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth

Tittelbaum

2. Date of Death

Month  
MarchDay  
7Year  
2007

3. Time of Death

10:31 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Manor Health Care

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

128-03-4186

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 6, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

328 Hances Point

10f. Zip Code

21901-5333

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Frank Wagner

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Judy Squire (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

328 Hances Point, North East, MD 21901-5333

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Sharon Cem.

Date

3/9/2007

20c. Location - City or Town, State

Springfield, PA

21. Signature of Funeral Service Licensee

Alan Schaefer

22. Name and Address of Facility

Schoenberg Memorial Chapel  
519 Philadelphia Pike, Wilm., DE 1980923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

PARKINSON'S

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Roy D. ...

29c. License number

H53419

29d. Date signed (Month, Day, Year)

MARCH 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rooney D. ... 1381 TOURNAI ROAD Rising Sun MD 21111

31. Date filed (Month, Day, Year)

MAR 14 2007

32. Registrar's Signature

Roy D. ...

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08079

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

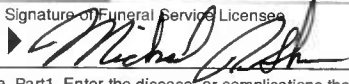

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Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sophie Marcus Triebwasser</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>2:30 A M</b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Eldercare Severna Park</b>   |  | 4b. City, Town, or Location of Death<br><b>Severna Park</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |
| 5. Social Security Number<br><b>100-14-9731</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>July 6, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>319 Carriage Run Road</b>  |  |  |
| 10f. Zip Code<br><b>21403</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Morris Marcus</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yetta (unknown)</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James I. Triebwasser/son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>319 Carriage Run Road Annapolis, Maryland 21403</b>   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home<br/>147 Duke of Gloucester St., Annapolis, MD 21401</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Aspiration pneumonia</b>   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 d</b>   |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |  | 23d. Date of delivery<br>Month Day Year  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D32036</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/26/2007</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary J. Spruill 2108 W. D. Drive Chester, MD 21619</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 27 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Brett

Thomas

2. Date of Death

Month Day Year  
February 22, 2007

3. Time of Death

1631 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Route 301 at Governor Nice Bridge

4b. City, Town, or Location of Death

Newburg

4c. County of Death

Charles

5. Social Security Number

231-15-2056

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

Yrs

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

02/26/1964

9. Birthplace (State or Foreign Country)

IL.

Usual Residence of Decedent

10a. State

MD

10b. County

St. Marys

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27171 Oliver Lane

10f. Zip Code

20659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year 88/90

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

White

Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Contractor

17. Father's Name (First, Middle, Last)

Edmund

K.

Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Angela

M.

Hammond

19a. Informant's Name/Relationship (Type, Print)

Daphne K. Thomas Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 Woodstock Road Richmond, VA 23224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

02/26.07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

Hardesty Funeral Home P.A. 12 Ridgely Ave  
Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Feb 20, 2007

28b. Time of Injury

1125 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject off bridge

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) River

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Route 301 at Governor Nice Bridge, Newburg, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 23, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, MD 21215-0036

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2007 08081

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MEARN L. THOMPSON</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>26</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>9:47A</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| 5. Social Security Number<br><b>448 18 8859</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 12, 1925</b>  | 9. Birthplace (State or Foreign Country)<br><b>TEXAS</b>   |  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>PRINCE GEORGES</b>                                       | 10c. City, Town or Location<br><b>CAMP SPRINGS</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>6307 BRINKLEY COURT</b>  |  | 10f. Zip Code<br><b>20748</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 1+  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GOVERNMENT EMPLOYEE</b>   |  | 16b. Kind of Business/Industry<br><b>FEDERAL GOVERNMENT</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>FRANCES THOMPSON</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA M WOOTEN</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LUCIE H. THOMPSON</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6307 BRINKLEY COURT CAMP SPRINGS, MD 20748</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>03/03/2007 SUITLAND, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>J. P. Marshall</i>  |  | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME OF MARYLAND, INC.<br/>4308 SUITLAND ROAD SUITLAND, MD 20746</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Upper Gastrointestinal Bleed</b><br>Due to (or as a consequence of):<br><b>b. Lung Cancer with metastases</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  | Approximate Interval Between Onset and Death |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>post radiation esophageal narrowing</b>  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)               |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>S. Banks, MD</i>  |  | 29c. License number<br><b>D0062057</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-27-07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sandra Banks, MD 7503 SURRATTS ROAD CLINTON, MD 20735</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  | 32. Registrar's Signature<br><i>James D. Spivey</i>  |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08082

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Thornes

2. Date of Death

February 25, 2007

3. Time of Death

11:04aM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Arundel

5. Social Security Number

579-56-4461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Feb 11, 1944

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State  
DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Atlantic Street SE

10f. Zip Code

20032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Dept of Treasury

17. Father's Name (First, Middle, Last)

Wesley Solomon

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Elder

19a. Informant's Name/Relationship (Type, Print)

Cynthia Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1313 Belmont Street NW Wash, DC 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Quantico Nat Cem

Date

03/05/07

20c. Location - City or Town, State

Triangle Virginia

21. Signature of Funeral Service Licensee

Tyrone J. Young

22. Name and Address of Facility

Tyrone J. Young 719 Kennedy St. NW Wash DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Anoxic encephalopathy

b. Due to (or as a consequence of):

Liver failure

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. J. A. Weinstein MD

29c. License number

D38445

29d. Date signed (Month, Day, Year)

02/26/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. J. A. Weinstein 2001 Medical Parkway Anne Arundel Md 21401

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Karen D. Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08083

Amended#5, F.D. 1-

For  
State  
Registrar

TCHD, 02/27/07, sbb

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald C. Turner, Sr.

2. Date of Death

February 10 2007

3. Time of Death

1147 AM

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

214-42-9130

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-05-1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26981 Tunis Mills Road

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner -Operator

16b. Kind of Business/Industry

Turner's Heating Air Conditions

17. Father's Name (First, Middle, Last)

Howard Otis Turner

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Jackson

19a. Informant's Name/Relationship (Type, Print)

Ernestine Turner / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O.Box 1414, Easton, Maryland 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Richards Memorial Cem

Date

02-17-2007

20c. Location - City or Town, State

Easton, Maryland

21. Signature of Funeral Service Licensee

Jammie Y. Shaw

22. Name and Address of Facility

Bennie Smith Funeral Home

426 Dover Street, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Small Cell Lung Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

2 days

c. Acute Heart Failure

Due to (or as a consequence of):

1 day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ludwig J. Eglseider, III

29c. License number

D31466

29d. Date signed (Month, Day, Year)

2/10/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ludwig J. Eglseider, III 503 Cynwood Ave Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 14 2007

32. Registrar's Signature

[Signature]

Turner, Ronald C.  
Baltimore, Maryland 21215-0036  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

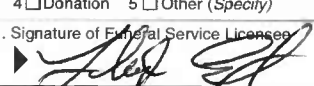


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08084

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas A Turner</b>  |  | 2. Date of Death<br>Month Day Year<br><b>February 22 2007</b>  |  | 3. Time of Death<br><b>11:00 PM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Civista Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>LaPlata</b>   |  | 4c. County of Death<br><b>Charles</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-40-5271</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>08/25/1936</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Charles</b>  |  | 10c. City, Town or Location<br><b>LaPlata</b>  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |
|   | 10e. Street and Number<br><b>101 Wesley Drive Apt. #222</b>   |  | 10f. Zip Code<br><b>20646</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver</b>                             |  | 16b. Kind of Business/Industry<br><b>Miller Lumber</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clarence A Turner</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Wright</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Turner / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>101 Wesley Dr. Apt 222 LaPlata, Maryland 20646</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Marys</b>   |  | 20c. Location - City or Town, State<br><b>03/02/2007 Bryantown, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Adams Funeral Home PA<br/>20605 Aquasco Rd. Aquasco, Maryland 20608</b>   |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. ILEUS</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  |  |  |
| 23b. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                       |   |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  |  |  |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 28d. Describe how injury occurred   |   |  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Michael A. Pimentel MD</b>   |   |  |  |  |  |
| 29c. License number<br><b>H- 0042445</b>  |   |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 23, 2007</b>   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael A. Pimentel 601 Post Office Rd Suite 1-A Waldorf, MD 20602</b>   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |   |  |  |  |  |
| 32. Registrar's Signature<br>  |   |  |  |  |  |

Turner, Thomas  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08085

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Molly Veney</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>22</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>8:10P<sup>M</sup></b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sligo Creek Nursing Home</b>   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>578-64-5732</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |
| Usual Residence of Decedent   |  | 10c. City, Town or Location<br><b>Landover</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>                                      | 10e. Street and Number<br><b>6810 Randolph St.</b>  |  | 10f. Zip Code<br><b>20784</b>  |
| 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>Aide/Teacher</b>  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Private</b>   |  | 16b. Kind of Business/Industry<br><b>Private</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Grant Penny</b>  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Emma McCoy</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda Brown/Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7508 Taylor St., Hyattsville, MD 20784</b>   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>   |
| 21. Signature of Funeral Service Licensee<br><b>John T. Stewart, III</b>  |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b><br><b>4001 Benning Rd., NE Wash., DC 20019</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardio-pulmonary Arrest</b>                                |
| 23b. Immediate Cause (Final disease or condition resulting in death)  |  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23d. Date of delivery<br>Month <b>2</b> Day <b>28</b> Year <b>07</b>   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |
| 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Nasreen Kango, M.D.</b>   |  | 29c. License number<br><b>56147</b>  |
| 29d. Date signed (Month, Day, Year)<br><b>2/28/07</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nasreen Kango, M.D. 7701 Carroll Ave., Takoma Park, MD 20912</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |
| 32. Registrar's Signature<br><b>Nasreen Kango</b>   |  | 33. Date of Death<br><b>2007</b>  |  | 34. Time of Death<br><b>8:10P<sup>M</sup></b>  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08086

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John T. Wade

2. Date of Death

February 22 2007 8:25A M

4a. Facility Name (If not institution, give street and number)

South River Health &amp; Rehab

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-44-7322

6. Sex

M 2 F

7. Age (In yrs. last birthday)

59 Yrs.

8. Date of Birth (Month, Day, Year)

Mar 8 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

410 Oaklawn Ave

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

John Wade

18. Mother's Name (First, Middle, Maiden Surname)

Raphaella Hawkins

19a. Informant's Name/Relationship (Type, Print)

Agnes Simms (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Oaklawn Ave Annapolis, Md. 21401

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Memorial Park

Date

3-2-07

20c. Location - City or Town, State

Annapolis, Md.

21. Signature of Funeral Service Licensee

Larry S. Reese M80483

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

b. Cardiac Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DDA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D07028

29d. Date signed (Month, Day, Year)

02-26-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aditya Chopra 600 Ridgely Ave #231 Annapolis MD 21401

31. Date filed (Month, Day, Year)

FEB 27 2007

32. Registrar's Signature

Karen B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08087

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Juan Avery Walker

2. Date of Death  
Month Day Year  
February 25, 20073. Time of Death  
0233 hrs

4a. Facility Name (if not institution, give street and number)

7018 Hanover Pkwy #D2

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-96-9911

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

Yrs.

If Under 1 Year

Months

If Under 24Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

Feb. 15, 1969

9. Birthplace (State, or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3287 15th Place, SE #1

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Logistics Specialist

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Bobby Walker

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Waul Waul

19a. Informant's Name/Relationship (Type, Print)

Gloria Waul Waul/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3287 15th Place, SE - Washington, DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

3/10/07

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Keith G. Sarge MD1055

22. Name and Address of Facility

Pope Funeral Homes, P.A.

5538 Marlboro Pike, Forestville, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact gunshot wound to head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Feb 2/25/2007

28b. Time of Injury

Feb 2:09 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

house

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7018 Hanover Pkwy. D2

Greenbelt, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela E. Southall, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 25, 2007

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 08 2007

32. Registrar's Signature

Juan A. Walker

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08088

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Lloyd White, Sr.

2. Date of Death  
Month Day Year

February 27, 2007

3. Time of Death

2:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

47 Cherry Street

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

216-20-1043

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

August 20, 1927

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

47 Cherry Street

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Marion Thomas White

18. Mother's Name (First, Middle, Maiden Surname)

Arvilla Mae Terry

19a. Informant's Name/Relationship (Type, Print)

Ruth White/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

47 Cherry Street, Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Brookview Cemetery

Date

3-3-2007

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

*Richard L. Goodie*

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.  
PO Box 248, 111 S. Queen St., Rising Sun MD 21911Approximate  
Interval Between  
Onset and Death23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Metastatic Rectal Carcinoma*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

D60768

29d. Date signed (Month, Day, Year)

2/28/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Jokhadar 281 E. Main St., Rising Sun, MD 21911

31. Date filed (Month, Day, Year)

MAR 1 2007

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08089

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Irene Wayman

2. Date of Death

February 24, 2007

3. Time of Death

3:25 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2729 Sprague Drive

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

5. Social Security Number

204-01-1443

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

July 25, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2729 Sprague Drive

10f. Zip Code

20601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Floyd Earnest

18. Mother's Name (First, Middle, Maiden Surname)

Marion Osborne

19a. Informant's Name/Relationship (Type, Print)

Richard Wayman/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3979 Tranquility Lane, King George, Virginia 22485

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

Date

2-27-2007

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

M01391

22. Name and Address of Facility

3035 Old Washington Road  
Huntt Funeral Home Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Advanced Atherosclerosis

Due to (or as a consequence of):

b. Chronic Renal Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

x years

x months

x years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEOFFREY H. WATKIN, M.D., WALDORF, MD 20603

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08090

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gregory Alexander Webb

2. Date of Death

February 16, 2007 2034<sup>P</sup>

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

215-62-1260

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-07-1955

9. Birthplace (State or Foreign Country)

Preston, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Cordova

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10499 Chapel Rd.

10f. Zip Code

21625

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

R. L. EWING

17. Father's Name (First, Middle, Last)

Wilmer Magee

18. Mother's Name (First, Middle, Maiden Surname)

Frances Webb

19a. Informant's Name/Relationship (Type, Print)

Veronica Warner Webb / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10499 Chapel Rd. Cordova, MD 21625

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Pleasant Cemetery

Date

2/24/2007

20c. Location - City or Town, State

Preston, MD

21. Signature of Funeral Service Licensee

Jammie Y. Shaw

22. Name and Address of Facility

Bennie Smith Funeral Home  
426 Dover St. Easton MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of):

b. Chronic Kidney Disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. H. H. , MD.

29c. License number

D0063359

29d. Date signed (Month, Day, Year)

2/17/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHUBA AUHTER, 607 DUTCHMAN LANE, EASTON, MD-21601

31. Date filed (Month, Day, Year)

FEB 22 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

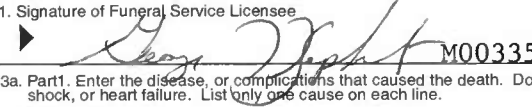
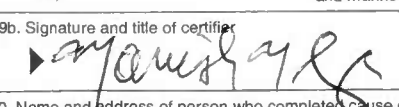

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08091

1- For  
State  
Registrar

|  |  |                                  |   |   |  |  |  |  |  |  |  |
|--|--|----------------------------------|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mirza Qamar Ahmad</b>                       |                                  |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>9</b> Year <b>2007</b> |  |  |  | 3. Time of Death<br><b>4:10 PM<sup>M</sup></b>                                 |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |                                  |   |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>              |  |  |  | 4c. County of Death<br><b>Montgomery</b>                                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>563-02-0325</b>  |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>March 31, 1946</b> |  | 9. Birthplace (State or Foreign Country)<br><b>India</b>                       |  |  |
|  | Usual Residence of Decedent  |                                  |   |   |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b> |   | 10c. City, Town or Location<br><b>Bethesda</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>9107 Charred Oak Drive</b>  |  |                                  |   | 10f. Zip Code<br><b>20817</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian Indian</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>   |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Financial Analyst</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>World Bank</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mirza Zafar Ahmad</b>  |  |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nasira Ahmad</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean P. Ahmad/ Wife</b>   |  |                                  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9107 Charred Oak Drive Bethesda, Maryland 20817</b>                                      |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium Inc.</b>  |  | Date<br><b>March 13, 2007</b>  |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>                               |  |  |  |
| 21. Signature of Funeral Service Licensee<br> M00335   |  |                                  |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                  |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |                                  |   |   |  |  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input checked="" type="checkbox"/> Other (specify) |  |
| 23d. Date of delivery<br>Month Day Year  |  |                                  |   |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                  |   |   |  |  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                                  |   |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                                  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                  |   |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |                                  |   | 29c. License number<br><b>D0057011</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/11/07</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mauish Oza, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814</b>  |  |                                  |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |                                  |   | Registrar's Signature<br>  |  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08092

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Merryman Buchan

2. Date of Death

Month Day Year  
March 14, 2007

3. Time of Death

3:27 A M

4a. Facility Name (If not institution, give street and number)

The Dove House

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

220-14-0367

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 15, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20 Dunvale Road, #403

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Merryman

18. Mother's Name (First, Middle, Maiden Surname)

Lily M. Dixon

19a. Informant's Name/Relationship (Type, Print)

Peter Buchan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

450 Morgan Ford Rd Front Royal, VA 22630

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc

Date

3/14/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
Septic Shock

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D63031

29d. Date signed (Month, Day, Year)

3/14/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yousuf Gaffar md, 555 South Carter Street Westminster, MD 21157

31. Date filed (Month, Day, Year)

MAR 15 2007

Registrar's Signature

John B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08093

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Irene Brettschneider

2. Date of Death

March 13, 2007

3. Time of Death

10:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3020 N. Ridge Rd W-126

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

212-09-4097

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3020 N. Ridge Rd, W-126

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Proof Reader

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Clarence Kyle

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hardy

19a. Informant's Name/Relationship (Type, Print)

William H. Brettschneider/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3020 N. Ridge Rd, W-126 Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc

Date

3/14/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd Baltimore, MD 2122823a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Alzheimer's Dementia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Attending Physician

29c. License number

D 30631

29d. Date signed (Month, Day, Year)

3/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Reisinger III MD 700 Geipe Rd, Catonsville, MD 21228

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

John W. Spiller

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- For Amend #10c, per FH, 8865, 3/15/07 IT  
 Certificate of Death

Reg. No.

2007 08094

|  |  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Clyde L Bell, Jr.</b>   |  |  |  | 2. Date of Death<br>Month <b>3</b> Day <b>14</b> Year <b>2007</b>   |  |   |   | 3. Time of Death<br><b>4:40 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2604 Chapel Lake Drive #406</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Gambrills</b>  |  |   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-38-2116</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 19, 1932</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>                                 |  |
|  | Usual Residence of Decedent  |  |  |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Gambrills</b><br><del>Gambrilla</del>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>2604 Chapel Lake Drive #406</b>   |  |  |  | 10f. Zip Code<br><b>21054</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                   |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1951-53</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Physician</b>   |  |   | 16b. Kind of Business/Industry<br><b>Medicine</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Clyde L. Bell, Sr.</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irma Whitworth</b>  |  |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty A. Bell / spouse</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2604 Chapel Lake Dr. #406 Gambrills, MD. 21054</b>  |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. Date<br><b>03/15/2007</b>  |  | 20d. Location - City or Town, State<br><b>Alexandria, VA.</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Chuan Powell</b>   |  |  |  | 22. Name and Address of Facility<br><b>Beall Funeral Home</b><br><b>6512 NW Crain Hwy. Bowie, MD. 20715</b>   |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Lung cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 month</b>                  |  |  |  |   |  |   |   |  |  |
|  | 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |  |  |   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br>26. Place of Death (Check only one)<br>27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. Signature and title of certifier<br><b>Rhee MD</b><br>29c. License number<br><b>D0064379</b><br>29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>   |  |  |  |  |   |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jay Rhee 900 Bestgate Rd Suite 300 Annapolis MD 21401</b>   |  |  |  |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b><br>32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08095

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence J. Bussard

2. Date of Death  
Month Day Year

March 11 2007

3. Time of Death

1:15 P M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

184-40-3844

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 14, 1948

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18954 Ferry Landing Circle

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Track and Structure

17. Father's Name (First, Middle, Last)

Clarence Bussard

18. Mother's Name (First, Middle, Maiden Surname)

Alice Taylor

19a. Informant's Name/Relationship (Type, Print)

Elsie Bussard / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18954 Ferry Landing Circle, Germantown, MD 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 14, 2007

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Angela Bussard

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Neurogenic fever

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alan S. Chanana

29c. License number

29413

29d. Date signed (Month, Day, Year)

March 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN S. CHANANA 15115 SHADY GROVE RD ROCKVILLE MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08096

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JACK</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>10</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>11:45 P M</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE HEBREW HOME</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>133-01-1076</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>08/09/1910</b> | 9. Birthplace (State or Foreign Country)<br><b>NY</b>   |
|   | Usual Residence of Decedent   |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>2434 W. BELVEDERE AVENUE</b>   |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>BALTIMORE</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>SALESMAN</b>            |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GROCERY</b>   |  | 16b. Kind of Business/Industry<br><b>GROCERY</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>MAX</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>REBECCA TURITZ</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>LILLIAN BLUMENTHAL / WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4730 ATRIUM COURT #368 - OWINGS MILLS, MD 21117</b> |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR SINAI</b>  |  | 20c. Location - City or Town, State<br><b>03/13/2007 OWINGS MILLS, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                 |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>coronary artery disease</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>&lt; 2 hours</b><br><b>&gt; 6 months</b> |  |   |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |  |   |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |   |  |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |   |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Dementia, Dysphagia, Chronic renal failure</b>   |   |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |  |   |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |  |   |
| 28b. Time of Injury<br><b>M</b>   |   |  |   |  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |
| 28d. Describe how injury occurred   |   |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |
| 29b. Signature and title of certifier<br><b>Begum, MD</b>   |   |  |   |  |   |
| 29c. License number<br><b>D0053928</b>  |   |  |   |  |   |
| 29d. Date signed (Month, Day, Year)<br><b>03/11/07</b>  |   |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURAIYA BEGUM, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD - 21215</b>   |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |   |  |   |  |   |
| 32. Registrar's Signature<br>   |   |  |   |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


1- For State Registrar **Amend Items 23a, 25, 27, 28a-f per me, 2873, 11/09/07/dnb** State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2007 08097

Physician  
/Medical  
Examiner


Funeral  
Director

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Citro</b>  |  |  |  | 2. Date of Death<br>Month <b>03</b> Day <b>13</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>11:00 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>216-24-4801</b>   |  | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>8/8/1923</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><b>1 X Yes 2 No</b>  |  | 10e. Street and Number<br><b>3701 Frankford Ave.</b>   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><b>1 X Never Married 2 Married 3 X Widowed 4 Divorced</b>                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 No</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 X Yes 2 No Specify:</b>    |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Clifton Lee Jackson</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Westerman</b>                                |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen M. Citro</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3701 Frankford Ave. Baltimore, MD 21206</b> |  | 20a. Method of Disposition<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>            |  | 20c. Date<br><b>3/17/2007</b>  |  | 20d. Location - City or Town, State<br><b>Parkville, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br> |  |
| 22. Name and Address of Facility<br><b>Baltimore, MD 21214</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Stroke</b> |  | 23b. Immediate Cause (Final disease or condition resulting in death)<br><b>Head Trauma s/p Fall</b>   |  | Approximate Interval Between Onset and Death<br><b>6 hours</b>   |  |
| 23c. Due to (or as a consequence of):<br><b>Intracerebral Hemorrhage</b>                                      |  | 23d. Due to (or as a consequence of):<br><b>Subdural Hematoma</b>  |  | 23e. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>6 hours</b>   |  |
| 23f. Due to (or as a consequence of):   |  | 23g. Due to (or as a consequence of):  |  | 23h. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>6 hours</b>   |  |
| 23i. Due to (or as a consequence of):   |  | 23j. Due to (or as a consequence of):  |  | 23k. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23l. Due to (or as a consequence of):   |  | 23m. Due to (or as a consequence of):  |  | 23n. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23o. Due to (or as a consequence of):   |  | 23p. Due to (or as a consequence of):  |  | 23q. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23r. Due to (or as a consequence of):   |  | 23s. Due to (or as a consequence of):  |  | 23t. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23u. Due to (or as a consequence of):   |  | 23v. Due to (or as a consequence of):  |  | 23w. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23x. Due to (or as a consequence of):   |  | 23y. Due to (or as a consequence of):  |  | 23z. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| 23aa. Due to (or as a consequence of):  |  | 23ab. Due to (or as a consequence of):   |  | 23ac. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ad. Due to (or as a consequence of):  |  | 23ae. Due to (or as a consequence of):   |  | 23af. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ag. Due to (or as a consequence of):  |  | 23ah. Due to (or as a consequence of):   |  | 23ai. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23aj. Due to (or as a consequence of):  |  | 23ak. Due to (or as a consequence of):   |  | 23al. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23am. Due to (or as a consequence of):  |  | 23an. Due to (or as a consequence of):   |  | 23ao. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ap. Due to (or as a consequence of):  |  | 23aq. Due to (or as a consequence of):   |  | 23ar. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23as. Due to (or as a consequence of):  |  | 23at. Due to (or as a consequence of):   |  | 23au. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23av. Due to (or as a consequence of):  |  | 23aw. Due to (or as a consequence of):   |  | 23ax. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ay. Due to (or as a consequence of):  |  | 23az. Due to (or as a consequence of):   |  | 23ba. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23b. Due to (or as a consequence of):   |  | 23bb. Due to (or as a consequence of):   |  | 23bc. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23c. Due to (or as a consequence of):   |  | 23bd. Due to (or as a consequence of):   |  | 23be. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23d. Due to (or as a consequence of):   |  | 23bf. Due to (or as a consequence of):   |  | 23bg. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23e. Due to (or as a consequence of):   |  | 23bh. Due to (or as a consequence of):   |  | 23bi. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23f. Due to (or as a consequence of):   |  | 23bj. Due to (or as a consequence of):   |  | 23bk. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23g. Due to (or as a consequence of):   |  | 23bl. Due to (or as a consequence of):   |  | 23bm. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23h. Due to (or as a consequence of):   |  | 23bn. Due to (or as a consequence of):   |  | 23bo. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23i. Due to (or as a consequence of):   |  | 23bp. Due to (or as a consequence of):   |  | 23bq. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23j. Due to (or as a consequence of):   |  | 23br. Due to (or as a consequence of):   |  | 23bs. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23k. Due to (or as a consequence of):   |  | 23bt. Due to (or as a consequence of):   |  | 23bu. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23l. Due to (or as a consequence of):   |  | 23bv. Due to (or as a consequence of):   |  | 23bw. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23m. Due to (or as a consequence of):   |  | 23bx. Due to (or as a consequence of):   |  | 23by. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23n. Due to (or as a consequence of):   |  | 23bz. Due to (or as a consequence of):   |  | 23ca. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23o. Due to (or as a consequence of):   |  | 23cb. Due to (or as a consequence of):   |  | 23cc. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23p. Due to (or as a consequence of):   |  | 23cd. Due to (or as a consequence of):   |  | 23ce. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23q. Due to (or as a consequence of):   |  | 23cf. Due to (or as a consequence of):   |  | 23cg. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23r. Due to (or as a consequence of):   |  | 23ch. Due to (or as a consequence of):   |  | 23ci. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23s. Due to (or as a consequence of):   |  | 23cj. Due to (or as a consequence of):   |  | 23ck. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23t. Due to (or as a consequence of):   |  | 23cl. Due to (or as a consequence of):   |  | 23cm. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23u. Due to (or as a consequence of):   |  | 23cn. Due to (or as a consequence of):   |  | 23co. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23v. Due to (or as a consequence of):   |  | 23cp. Due to (or as a consequence of):   |  | 23cq. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23w. Due to (or as a consequence of):   |  | 23cr. Due to (or as a consequence of):   |  | 23cs. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23x. Due to (or as a consequence of):   |  | 23ct. Due to (or as a consequence of):   |  | 23cu. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23y. Due to (or as a consequence of):   |  | 23cv. Due to (or as a consequence of):   |  | 23cw. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23z. Due to (or as a consequence of):   |  | 23cx. Due to (or as a consequence of):   |  | 23cy. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23aa. Due to (or as a consequence of):  |  | 23cz. Due to (or as a consequence of):   |  | 23da. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ab. Due to (or as a consequence of):  |  | 23db. Due to (or as a consequence of):   |  | 23dc. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ac. Due to (or as a consequence of):  |  | 23dd. Due to (or as a consequence of):   |  | 23de. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ad. Due to (or as a consequence of):  |  | 23de. Due to (or as a consequence of):   |  | 23df. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ae. Due to (or as a consequence of):  |  | 23df. Due to (or as a consequence of):   |  | 23dg. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23af. Due to (or as a consequence of):  |  | 23dg. Due to (or as a consequence of):   |  | 23dh. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ag. Due to (or as a consequence of):  |  | 23dh. Due to (or as a consequence of):   |  | 23di. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ah. Due to (or as a consequence of):  |  | 23di. Due to (or as a consequence of):   |  | 23dj. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ai. Due to (or as a consequence of):  |  | 23dj. Due to (or as a consequence of):   |  | 23dk. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23aj. Due to (or as a consequence of):  |  | 23dk. Due to (or as a consequence of):   |  | 23dl. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ak. Due to (or as a consequence of):  |  | 23dl. Due to (or as a consequence of):   |  | 23dm. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23al. Due to (or as a consequence of):  |  | 23dm. Due to (or as a consequence of):   |  | 23dn. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23am. Due to (or as a consequence of):  |  | 23dn. Due to (or as a consequence of):   |  | 23do. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23an. Due to (or as a consequence of):  |  | 23do. Due to (or as a consequence of):   |  | 23dp. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ao. Due to (or as a consequence of):  |  | 23dp. Due to (or as a consequence of):   |  | 23dq. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ap. Due to (or as a consequence of):  |  | 23dq. Due to (or as a consequence of):   |  | 23dr. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23aq. Due to (or as a consequence of):  |  | 23dr. Due to (or as a consequence of):   |  | 23ds. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23ar. Due to (or as a consequence of):  |  | 23ds. Due to (or as a consequence of):   |  | 23dt. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23as. Due to (or as a consequence of):  |  | 23dt. Due to (or as a consequence of):   |  | 23du. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23at. Due to (or as a consequence of):  |  | 23du. Due to (or as a consequence of):   |  | 23dv. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |
| 23au. Due to (or as a consequence of):  |  | 23dv. Due to (or as a consequence of):   |  | 23dv. Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Stroke</b> |  |  |  | 23b. Immediate Cause (Final disease or condition resulting in death)<br><b>Head Trauma s/p Fall</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>6 hours</b> |  |  |  |
| 23c. Due to (or as a consequence of):<br><b>Intracerebral Hemorrhage</b>   |  |  |  | 23d. Due to (or as a consequence of):<br><b>Subdural Hematoma</b>                                   |  |  |  | 23e. Due to (or as a consequence of):                          |  |  |  |
| 23f. Due to (or as a consequence of):  |  |  |  | 23g. Due to (or as a consequence of):   |  |  |  | 23h. Due to (or as a consequence of):                          |  |  |  |
| 23i. Due to (or as a consequence of):  |  |  |  | 23j. Due to (or as a consequence of):   |  |  |  | 23k. Due to (or as a consequence of):                          |  |  |  |
| 23l. Due to (or as a consequence of):  |  |  |  | 23m. Due to (or as a consequence of):   |  |  |  | 23n. Due to (or as a consequence of):                          |  |  |  |
| 23o. Due to (or as a consequence of):  |  |  |  | 23p. Due to (or as a consequence of):   |  |  |  | 23q. Due to (or as a consequence of):                          |  |  |  |
| 23r. Due to (or as a consequence of):  |  |  |  | 23s. Due to (or as a consequence of):   |  |  |  | 23t. Due to (or as a consequence of):                          |  |  |  |
| 23u. Due to (or as a consequence of):  |  |  |  | 23v. Due to (or as a consequence of):   |  |  |  | 23w. Due to (or as a consequence of):                          |  |  |  |
| 23x. Due to (or as a consequence of):  |  |  |  | 23y. Due to (or as a consequence of):   |  |  |  | 23z. Due to (or as a consequence of):                          |  |  |  |
| 23aa. Due to (or as a consequence of):   |  |  |  | 23ab. Due to (or as a consequence of):  |  |  |  | 23ac. Due to (or as a consequence of):                         |  |  |  |
| 23ad. Due to (or as a consequence of):   |  |  |  | 23ae. Due to (or as a consequence of):  |  |  |  | 23af. Due to (or as a consequence of):                         |  |  |  |
| 23ag. Due to (or as a consequence of):   |  |  |  | 23ah. Due to (or as a consequence of):  |  |  |  | 23ai. Due to (or as a consequence of):                         |  |  |  |
| 23aj. Due to (or as a consequence of):   |  |  |  | 23ak. Due to (or as a consequence of):  |  |  |  | 23al. Due to (or as a consequence of):                         |  |  |  |
| 23am. Due to (or as a consequence of):   |  |  |  | 23an. Due to (or as a consequence of):  |  |  |  | 23ao. Due to (or as a consequence of):                         |  |  |  |
| 23ap. Due to (or as a consequence of):   |  |  |  | 23aq. Due to (or as a consequence of):  |  |  |  | 23ar. Due to (or as a consequence of):                         |  |  |  |
| 23as. Due to (or as a consequence of):   |  |  |  | 23at. Due to (or as a consequence of):  |  |  |  | 23au. Due to (or as a consequence of):                         |  |  |  |
| 23av. Due to (or as a consequence of):   |  |  |  | 23av. Due to (or as a consequence of):  |  |  |  | 23av. Due to (or as a consequence of):                         |  |  |  |

|  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 X Yes 2 No 9 Unknown</b>   |  |  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b>                |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 X Yes 2 No 3 Probably 4 Unknown</b>   |  |  |  |
| 24a. Was an autopsy performed?<br><b>1 X Yes 2 No</b>  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 X Yes 2 No</b>  |  |  |  | 24c. Were autopsy findings available prior to completion of cause of death?<br><b>1 X Yes 2 No</b>   |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 X Yes 2 No</b>  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>    |  |  |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>                                  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>03/13/2007</b>  |  |  |  | 28b. Time of Injury<br><b>Unknown</b>   |  |  |  | 28c. Injury at Work?<br><b>1 X Yes 2 No</b>  |  |  |  |
| 28d. Describe how injury occurred<br><b>Tripped over broken sidewalk, fell hit head on concrete</b>  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Intersection of Gibbons Ave. &amp; Walther Ave. Baltimore, MD 21214</b> |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  | 29b. Signature and title of certifier<br><b>Nicole Hale</b>   |  |  |  | 29c. License number<br><b>255-000</b>  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 14th, 2007</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr Ricardo Rosa 4940 EASTERN AVENUE BALTIMORE, MD, 21224</b> |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |  |  |
| 32. Registrar's Signature<br>   |  |  |  | 33. Registrar's Title<br><b>Registrar</b>   |  |  |  | 34. Registrar's Office<br><b>State Registrar</b>   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

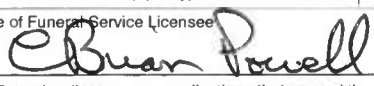


Reg. No. 2007 03098

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anthony Salvatore Clavio</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>9:45 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>12513 Kensington Lane</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bowie</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>208-12-9227</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 6, 1926</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>12513 Kensington Lane</b>  |  |   |  | 10f. Zip Code<br><b>20715</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>WW II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Systems Analyst</b>   |  | 16b. Kind of Business/Industry<br><b>U.S.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Paolo Clavio</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carmella Migliaccio</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Norine A. Clavio / spouse</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12513 Kensington Lane Bowie, MD. 20715</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crownsville Vet. Cem.</b>  |  | 20c. Date<br><b>03/15/2007</b>   |  | 20d. Location - City or Town, State<br><b>Crownsville, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Beall Funeral Home</b><br><b>6512 NW Crain Hwy. Bowie, Maryland 20715</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myelodysplasia</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |  |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b><br><b>Thrombocytopenia</b>  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D23743</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 14, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin D. Weltz, M.D. 7525 Greenway Center Dr. #205 Greenbelt, MD 20770</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007-08099

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vennie Underwood Cosby

2. Date of Death

March 7, 2007

3. Time of Death

10:30 P M

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

213-38-7111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 3, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane, #BR207

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Samuel Lee Underwood

18. Mother's Name (First, Middle, Maiden Surname)

Cora Belle Thomas

19a. Informant's Name/Relationship (Type, Print)

Mr. James Reginald Cosby, Husband 719 Maiden Choice Lane, #BR207, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gns. March 13, 2007 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

MD1113

22. Name and Address of Facility

Brian T. Chisholm Funeral Services of  
Dulaney Valley, P.A. 200 Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

DCC 28040

29d. Date signed (Month, Day, Year)

3/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Underwood 711 Maiden Choice Lane Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

57

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Amend Item 1, 29d per dr. 8865, 03/15/07dhh

Certificate of Death

Reg. No.

2007 08100

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Dipietro

2. Date of Death

03-03-07

3. Time of Death

9:31 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217 26 8776

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

8. Date of Birth

October 17 1929

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11612 Cedar Lane

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck driver

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Pasquale DiPietro

18. Mother's Name (First, Middle, Maiden Surname)

Anna Juliano

19a. Informant's Name/Relationship (Type, Print)

Joan M DiPietro

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11612 Cedar Lane Kingsville, Maryland 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

March 7 2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Deborah Lassahn

22. Name and Address of Facility

EF Lassahn Funeral Home PA

11750 Belair Road

Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 1/2

years

years

years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D34 931

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anne C. Morrell 4136 B E Joppa Rd. Balto. MD 21236

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Anne C. Morrell

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08101

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Emily Dhillon

2. Date of Death

March 12, 2007

3. Time of Death

7:00 a. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2302 Westchester Ave

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

277-20-2302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

February 8, 1924

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2302 Westchester Ave

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher / Writer

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Seymour Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Peterson

19a. Informant's Name/Relationship (Type, Print)

Mr. Raghbir S. Dhillon Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2302 Westchester Ave Catonsville, Maryland 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation Services, Inc.

Date

03/13/2007

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

Melody R. Taylor

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

probable acute pulmonary embolism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

deep venous thrombosis

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent subtotal colectomy and ileostomy for colon perforation  
myasthenia gravis due to bowel ischemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bernita C. Taylor MD

29c. License number

D33212

29d. Date signed (Month, Day, Year)

3/12/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernita C. Taylor MD 700 Beiperd st 200 Catonsville Md 21228

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Bernita C. Taylor

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2007 08102

1. For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|   |  |                                     |
|---|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Douglas Davis</b> | 2. Date of Death<br>Month <b>March</b> Day <b>8</b> Year <b>2007</b> | 3. Time of Death<br><b>0417 hrs</b> |
|---|--|-------------------------------------|

Funeral  
Director

|  |  |   |
|--|--|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>12 1/2 Edmondson Ridge Road</b> | 4b. City, Town, or Location of Death<br><b>Catonsville</b>                 | 4c. County of Death<br><b>Baltimore County</b>        |
| 5. Social Security Number<br><b>213-50-1822</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.      |
| 8. Date of Birth (MM/DD/YYYY)<br><b>Aug. 23, 1963</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |

|                             |                                 |   |  |
|-----------------------------|---------------------------------|---|--|
| Usual Residence of Decedent |                                 |   |  |
| 10a. State<br><b>MD</b>     | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Catonsville</b> | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |

|  |                               |   |
|--|-------------------------------|---|
| 10e. Street and Number<br><b>12 1/2 Edmondson Ridge Road</b> | 10f. Zip Code<br><b>21228</b> | 10g. Citizen of What Country?<br><b>United States</b> |
|--|-------------------------------|---|

|  |  |  |   |
|--|--|--|---|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|--|--|--|---|

|   |   |   |
|---|---|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b> | 16b. Kind of Business/Industry<br><b>Equestrian</b> |
|---|---|---|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Quillian J. Davis</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thelma Ann Armiger</b> |
|---|--|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ann Davis - Mother</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 1/2 Edmondson Ridge Rd., Catonsville, MD 21228</b> |
|---|---|

|  |  |  |
|--|--|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, church, or other place)<br><b>Lorriam Park Cemetery</b> | 20c. Location - City or Town, State<br><b>3-15-2007 Woodlawn, MD</b> |
|--|--|--|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br><i>Catharine [Signature]</i> | 22. Name and Address of Facility<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Rd., Arbutus, MD 21227</b> |
|---|--|

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Asphyxia</b> | Approximate Interval Between Onset and Death |
|---|--|

|  |                                     |
|--|-------------------------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |
|--|-------------------------------------|

|                                     |                                     |
|-------------------------------------|-------------------------------------|
| c. Due to (or as a consequence of): | d. Due to (or as a consequence of): |
|-------------------------------------|-------------------------------------|

|   |  |
|---|--|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>#23a, 27, 28a-f, per ME, g865, 3/17/07 TT</b> |  |
|---|--|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene |
|---|---|

|   |   |   |   |   |
|---|---|---|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br><b>Fnd 3/8/2007</b> | 28b. Time of Injury<br><b>Fnd 3:15 am</b> | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>subject accidentally asphyxiated self</b> |
|---|---|---|---|---|

|   |  |
|---|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>found in residence</b> | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>12 1/2 Edmondson Ridge Road Catonsville, MD</b> |
|---|--|

|   |   |  |   |
|---|---|--|---|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Melissa Brassell MD</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>March 8, 2007</b> |
|---|---|--|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b> |
|---|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b> | 32. Registrar's Signature<br><i>[Signature]</i> |
|---|---|

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08103

1- For State  
RegistrarPhysician/  
Medical ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>James William Fabian</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>6</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>0226 hrs</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>11 Mann Ave</b>  |  | 4b. City, Town, or Location of Death<br><b>Brooklyn</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>216-86-0904</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.   |  |
| 8. Date of Birth (MM/DD/YYYY)<br><b>Sept 15, 1970</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>N/A</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>4201 Twin Circle Way</b>   |  | 10f. Zip Code<br><b>21227</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouseman</b>                      |  | 16b. Kind of Business/Industry<br><b>Distribution</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Louis Fabian, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosemary Barbara Loney</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosemary B. Fabian/Mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4201 Twin Circle Way Baltimore MD 21227</b>       |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>West Arundel Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3-13-2007 Odenton, Maryland</b>  |  |
| 21. Signature of Funeral Service Director<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home of Lansdowne</b><br><b>2719 Hammonds Ferry Rd. Lansdowne MD 21227</b>                     |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Gunshot wound of chest</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>d. <b>item #a, per ME, C865, 3/15/07, WS</b> |  |   |  |  |  |
| Approximate Interval Between Onset and Death  |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Mar 6, 2007</b>  |  | 28b. Time of Injury<br><b>0221 hrs</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Subject shot</b>  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Mobile Home</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>11 Mann Ave, Brooklyn, MD</b>                                      |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 7, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

Baltimore, MD 21215-0036

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08104

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SERENITY ARRIANA FOSTER

2. Date of Death

Month 3 Day 7 Year 07

3. Time of Death

12:15A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SD. MD. HOSP. CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3-6-07

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

604 SPRINGFIELD AVE.,

10f. Zip Code

21212

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

-0-

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

PARRIS FOSTER

18. Mother's Name (First, Middle, Maiden Surname)

TIANA MILLER

19a. Informant's Name/Relationship (Type, Print)

TIANA MILLER/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 SPRINGFIELD AVE., BALTIMORE, MD. 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

3-14-07

20c. Location - City or Town, State

BELTSVILLE, MD.

21. Signature of Funeral Service Licensee

Marion Johnson Jolley

22. Name and Address of Facility CAPITOL MORTUARY INC.

1425 MARYLAND AVE., N.E. WASH., D.C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Severe Immaturity

Due to (or as a consequence of):

b. Premature Labor.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

SALEM I. AL-NABER M.D.

29c. License number

D33268

29d. Date signed (Month, Day, Year)

3-7-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALEM I. AL-NABER 7503 SURRETTIS RD. CLINTON, MD. 20735

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08105

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Claire Fischer</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 14, 2007</b>  |  | 3. Time of Death<br><b>5:00 a. M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>7333 Eden Brook Dr.</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>   |  |
| 5. Social Security Number<br><b>116-22-2954</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 4, 1929</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |  |  |  |  |  |  |
| Usual Residence of Decedent  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>7333 Eden Brook Dr.</b>   |  |  |  | 10f. Zip Code<br><b>21046</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>  |  | 16b. Kind of Business/Industry<br><b>Healthcare</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas Francis Counihan</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anne Whalen</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Carl Fischer, III Son</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7333 Eden Brock Dr. Columbia, Maryland 21046</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  | 20d. Date<br><b>3/14/07</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Melody Baker Brightman</i>   |  |  |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21042</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Abdominal Aortic Aneurysm</b><br>Due to (or as a consequence of):<br><b>b. Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br><b>c. </b><br>Due to (or as a consequence of):<br><b>d. </b> |  |  |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b>   |  |  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>Steven A. Geller</i>   |  | 29c. License number<br><b>D34613</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Mar 14, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Geller, Steven A. MD 8186 Lark Brown Rd. Suite 201 Elkridge, MD 21075</b>   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  | 32. Registrar's Signature<br><i>Kevin K. Geller</i>  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08106

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Evette R. Gilmore</b>  |  | 2. Date of Death<br>Month <b>3</b> Day <b>13</b> Year <b>07</b>  |  | 3. Time of Death<br><b>10:47A</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5723 Willowton Ave</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death   |  |
| 5. Social Security Number<br><b>220-92-2547</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br><b>39</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>8-12-67</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>5723 Willowton Avenue</b>   |  | 10f. Zip Code<br><b>21239</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Data Analysis</b>  |  | 16b. Kind of Business/Industry<br><b>Health Care</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles A. Jones</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Linda Glover</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William H. Gilmore Jr. (Husband)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5723 Willowton Ave, Balto. MD 21239</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/17/07 Baltimore, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Fun W. Liu</b>  |  | 22. Name and Address of Facility<br><b>Vaughn C. Greene Funeral Services</b><br><b>4905 York Rd, Balto. MD 21212</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast Cancer with Metastases to Liver and Lung</b>  |  | Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>8 years</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | Due to (or as a consequence of):   |  |   |  |
| Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  |   |  |
| Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Nguyen Physician</b>   |  | 29c. License number<br><b>D0053275</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>March 13, 2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>QUAN DANG NGUYEN, MD, 600 N. Wolfe St, Baltimore, MD 21287</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  | 32. Registrar's Signature<br><b>James B. Smith</b>   |  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08107

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Geter

2. Date of Death

Month  
03Day  
11Year  
07

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-32-5878

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/03/1937

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

294 South Spring Court

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
2 years16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

Ruben Geter

18. Mother's Name (First, Middle, Maiden Surname)

Leatha Robinson

19a. Informant's Name/Relationship (Type, Print)

Harrison Geter/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5444 Bellevista Avenue Balto. MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

03/15/07

20c. Location - City or Town, State

Woodlawn MD

21. Signature of Funeral Service Licensee

W. W. Sw

22. Name and Address of Facility

Vaughn C. Greene Funeral Svcs  
4905 York Road Balto. MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. W. Sw

29c. License number

D43725

29d. Date signed (Month, Day, Year)

3/12/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

W. W. Sw

State  
Registrar

MARCH 11, 2007 7:20 a.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CHARLES GETER

Division or Vital Records, P.O. Box 68760, W.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08108

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rita S. Goldstein

2. Date of Death  
Month Day Year  
March 9, 20073. Time of Death  
1:15 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

119-03-5444

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 8, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4925 Battery Lane, #308

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Leo Miller

18. Mother's Name (First, Middle, Maiden Surname)

Anna Kaplan

19a. Informant's Name/Relationship (Type, Print)

Judith E. Goldstein/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7620 Old Georgetown Road, #1125, Bethesda, MD 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 13, 2007

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral/Service Licensee

Angelle Barant M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alpana Goswami M.D.

29c. License number

D27660

29d. Date signed (Month, Day, Year)

3/9/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Goswami, M.D. 11119 Rockville Pike, Suite G-100, Rockville, MD 20852

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Rita S. Goldstein

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #106, per FF, G865, 3/15/07, WS

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2007 08109

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS COHEN

GOODMAN

2. Date of Death

March 12 2007

3. Time of Death

8:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JEWISH CONVALESCENT CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

219-03-2715

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02/16/1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

NY

10b. County

N/A  
~~NEW YORK~~

10c. City, Town or Location

NEW YORK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

525 WEST END AVENUE

10f. Zip Code

10024

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

SECRETARY

ARMED FORCES

17. Father's Name (First, Middle, Last)

HARRY

COHEN

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE

KASDAN

19a. Informant's Name/Relationship (Type, Print)

ELAINE EPSTEIN / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

525 WEST END AVENUE - NEW YORK, NY 10024

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ARLINGTON CHIZUK

Date

03/13/2007

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal failure

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. urosepsis

Due to (or as a consequence of):

d. Infected decubitus wound at sacrum

Approximate Interval Between Onset and Death

2 WKS

&gt; 2 WKS

&gt; 2 WKS

&gt; 1 month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Dysphagia, Anorexia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Doris Cohen, MD

29c. License number

D0053928

29d. Date signed (Month, Day, Year)

03/12/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURAIYA BELUM, MD  
2434 W. BELVEDERE AVE, BALTIMORE, MD - 21215

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Doris Cohen

State  
RegistrarDORIS COHEN GOODMAN  
Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 21208

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08110

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Margaret C. Gosciniak   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 11, 2007   |  | 3. Time of Death<br>11:13p <sup>M</sup>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Franklin Woods Nursing Home   |  |   |  | 4b. City, Town, or Location of Death<br>Rosedale   |  | 4c. County of Death<br>Baltimore Co.   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-12-1640  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>4-2-1923                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>MD  |  | 10b. County<br>Baltimore Co.   |  | 10c. City, Town or Location<br>Rosedale  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>1521 Chivalry Court   |  | 10f. Zip Code<br>21237   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
| To Be Completed by Funeral Director           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer  |  | 16b. Kind of Business/Industry<br>American Can Co.   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Andrew Wisniewski  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clara Kordonski   |  |  |  |
| To Be Completed by Funeral Director           | 19a. Informant's Name/Relationship (Type, Print)<br>Mildred C. Kalski - Sister  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10805 Howard Terrace Beltsville, MD 20705   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Stanislaus Cem.   |  | 20c. Date<br>3-14-07   |  | 20d. Location - City or Town, State<br>Dundalk, MD                                   |  |
| To Be Completed by Funeral Director           | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Kaczorowski Funeral Home, PA<br>1201 Dundalk Avenue Baltimore, MD 21222  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Myelodysplasia<br>a. Due to (or as a consequence of):<br>Parkinson's Disease<br>b. Due to (or as a consequence of):<br>Hypertension<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death<br>11-17-03<br>97   |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br>D-48025   |  | 29d. Date signed (Month, Day, Year)<br>March 12, 2007                                |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SARAH M. GARCIA, MD 1224 CHESTER AVE, BALTIMORE, MD 21237   |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 15 2007  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 8, per FH, G865, 3/1/5/07, WS

State of Maryland / Department of Health and Mental Hygiene

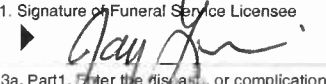

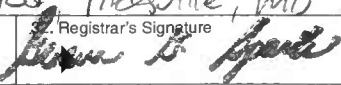
Certificate of Death

Reg. No. 2007 08111

1- For State Registrar

Physician / Medical Examiner

Funeral Director

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EMILY UDELL HYMAN</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>11</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>8:45 P<sup>M</sup></b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |
| 5. Social Security Number<br><b>215-09-2633</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>06/19/1913</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br><b>130 SLADE AVENUE APT. #420</b>  |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROPRIETOR</b>                        |  | 16b. Kind of Business/Industry<br><b>ARLINGTON MONUMENT CO.</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ABRAHAM MORRIS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESTHER FEINGOLD</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HANNAH FLAKS / DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4422 CLYDESDALE AVE - BALTIMORE, MD 21211</b>     |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW CONG.</b>   |  | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                     |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebral Vascular Accident</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>3 days</b> |  |   |  |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |
| 24. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>051426</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4000 Old Court Rd, Pikesville, MD 21208</b>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  | 32. Registrar's Signature<br>                                      |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08112

1- For State Registrar

1. Decedent's Name (First, Middle, Last)

Amy Mareth Henderson

2. Date of Death

Month Day Year  
March 10, 2007

3. Time of Death

0839 hrs

4a. Facility Name (if not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

218-68-0761

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (MM/DD/YYYY)

12/28/1957

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9220-L Bridle Path Lane

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Graphic Copier

16b. Kind of Business/Industry

Arts

17. Father's Name (First, Middle, Last)

Charles C. Henderson

18. Mother's Name (First, Middle, Maiden Surname)

Eileen Hickey

19a. Informant's Name/Relationship (Type, Print)

Ms. Eileen Henderson mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10803 Symphony Way Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Crematory

Date

3/15/07

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Melody Acker

22. Name and Address of Facility

Slack Funeral Home, P.A.

3871 Old Columbia Pike, Ellicott City, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia associated with chronic obstructive

Due to (or as a consequence of): pulmonary disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED

#25a, 27, per ME, g866, 4/26/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death

5 ☐ Other (Specify)

g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident

3 ☐ Suicide 6 ☐ Could not be determined

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Margarita Korell

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 11, 2007

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08113

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

TYRONE AARON JACKSON, JR.

2. Date of Death

Month Day Year  
March 13, 2007

3. Time of Death

0248 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215 19 6966

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

19

Yrs.

8. Date of Birth (MM/DD/YYYY)

NOV. 9, 1987

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6513 BROOK AVE.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ASSEMBLY WORKER

16b. Kind of Business/Industry

ATCO RUBBER CO.

17. Father's Name (First, Middle, Last)

TYRONE A. JACKSON, SR.

18. Mother's Name (First, Middle, Maiden Surname)

YOLANDA CAWTHORN

19a. Informant's Name/Relationship (Type, Print)

YOLANDA CAWTHORN/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6513 BROOK AVE. BALTO, MD. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH MAR. 17, 2007 BALTIMORE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Bernadine J. Scruggs*

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Shotgun Wound of Torso

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 6 ☐ Could not be determined4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

Mar 13, 2007

28b. Time of Injury

0230 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Single Family

28d. Describe how injury occurred

Subject shot

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6513 Brook Avenue, Baltimore, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

*Carol Hallan*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

*James L. Spivey*

Baltimore, MD 21215-0036

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08114

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Edward Jones</b>   |   | 2. Date of Death<br>Month Day Year<br><b>March 12, 2007</b>  |   | 3. Time of Death<br><b>9:45 a. M</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>160 Sanford Ave</b>  |   | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-52-6682</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>November 15, 1945</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Catonsville</b>  |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
|  | 10e. Street and Number<br><b>160 Sanford Ave.</b>   |   | 10f. Zip Code<br><b>21228</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bartender</b>                        |   | 16b. Kind of Business/Industry<br><b>Bartending</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Weldon Jones</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lelia McGruther</b>  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Karyn Bitzel Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>160 Sanford Ave. Catonsville, Maryland 21228</b> |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation Services, Inc.</b>                                 |   | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Melody Baker</b>  |   | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>                               |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Rectal Cancer</b> |   |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b>  |
|  | Due to (or as a consequence of):  |   |  |   |  |
|  | Due to (or as a consequence of):  |   |  |   |  |
|  | Due to (or as a consequence of):  |   |  |   |  |
|  | Due to (or as a consequence of):  |   |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |  |   |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown             |   |  |   |  |
|  | 23d. Date of delivery<br>Month Day Year   |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                                 |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Reed A. Bent</b>   |   | 29c. License number<br><b>D0038578</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/13/07</b>           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Fenton University of Maryland Cancer Center</b>   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08115

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel L. Kibler

2. Date of Death

February 7, 2007

3. Time of Death

8:40 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Summerville Assisted Living

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

224-12-1209

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

02/17/1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1798 Due North Drive

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

Jessie B. Lohr

18. Mother's Name (First, Middle, Maiden Surname)

Novie Lee Smith

19a. Informant's Name/Relationship (Type, Print)

Deborah Phillips/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1798 Due North Drive, Finksburg, MD 21048

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

per DVR

Ronald S. Wade, Director

22. Name and Address of Facility Baltimore, MD 21201

State Anatomy Board, 655 W. Baltimore Street

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Brain Tumour

Approximate Interval Between Onset and Death

not known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36409

29d. Date signed (Month, Day, Year)

February 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neel Kamal, M.D., 684 B. Poole Road, Westminster, MD

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08116

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARLENE SARAH KOZAK

2. Date of Death

Month Day Year  
MARCH 13, 2007

3. Time of Death

10:25 P.M.

4a. Facility Name (If not institution, give street and number)

GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-28-1890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

JUNE 26, 1934

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

GLENDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6414 SHERWOOD ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PUBLIC RELATIONS

16b. Kind of Business/Industry

A &amp; S TRAVEL

17. Father's Name (First, Middle, Last)

FRANK DI DONATO

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE TAYLOR

19a. Informant's Name/Relationship (Type, Print)

JOSEPH KOZAK/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6414 SHERWOOD ROAD BALTIMORE, MD 21239

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

3/16/2007

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer, pneumonia, myocardial infarction

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D58303

29d. Date signed (Month, Day, Year)

march 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARON J CHARLES MD 6701 W. Charles St Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08117

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosalina

Laboy

2. Date of Death

March 13 2007

Day Year

3. Time of Death

13<sup>26</sup> PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

066-34-2964

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

65 Yrs.

8. Date of Birth (Month, Day, Year)

10-1-1941

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

N.Y.

10b. County

Bronx

10c. City, Town or Location

Bronx

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120 Benchley Place

10f. Zip Code

10475

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

clerical

17. Father's Name (First, Middle, Last)

Louis Rosa

18. Mother's Name (First, Middle, Maiden Surname)

Margarita Perez

19a. Informant's Name/Relationship (Type, Print)

Carmen Rosa sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

120 Benchley Place Bronx, New York

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Raymonds Cem.

Date

3-19-2007

20c. Location - City or Town, State

Bronx, New York

21. Signature of Funeral Service Licensee

Carlton C. Douglas

22. Name and Address of Facility

Carlton C. Douglas Funeral Service P.A.  
1701 McCulloh St. Baltimore, Md. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions.

If any, include the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

history of breast cancer with reconstruction

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carlton C. Douglas M.D.

29c. License number

D59929

29d. Date signed (Month, Day, Year)

03-13-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aaron Marc Snyder Shady Grove Adventist. Rockville, Md.

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08118

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John J. Loewer</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>10</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>9:30 p<sup>m</sup></b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Towson</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>217-09-0878</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>7/27/1917</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2504 Wycliffe Road</b>   |  |   |  | 10f. Zip Code<br><b>21234</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>3</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pruduction Superispor</b>  |                                | 16b. Kind of Business/Industry<br><b>Spice Manufacturing</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Leonard Loewer</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katie Unknown</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maria Davis/ Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2504 Wycliffe Road Parkville, MD 21234</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greek Orthodox Cem.</b>  |  | Date<br><b>3/14/2007</b>   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, INC. 5305 Harford Road Baltimore, MD 21214</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hyper tension</b><br><b>Malnutrition</b><br><b>P.V.D.</b>  |  |   |  |  |                                |  |  |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>&gt; 2 years</b><br><b>&gt; 2 years</b><br><b>&gt; 2 years</b> |  |   |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |  |  |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                     |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>042736</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3-12-07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ayman Akkad 7600 Osler Dr. #411 Towson, MD 21204</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |                                |  |  |

March 10, 2007  
Baltimore, Maryland 21215-0036John J. Loewer  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2007 08119

|   |   |  |  |   |  |  |   |  |
|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEROY LARKINS</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MAR 13 2007</b>   |  | 3. Time of Death<br><b>08:05 AM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BALTIMORE VA MEDICAL CENTER</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-24-3379</b>   | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>12-14-1927</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b> |
|   | Usual Residence of Decedent   |  |  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                            |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md</b>   | 10b. County<br><b>N/A</b>  |  |   |  |  |   |  |
|   | 10e. Street and Number<br><b>3807 W. Mulberry St.</b>   |  |  |   | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Longshoreman</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Longshoreman</b> |   | 16b. Kind of Business/Industry<br><b>Port</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Larkins</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <b>Dr. Louise Johnson Cousin</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8908 Liberty Rd. Randallstown, Md. 21133</b> |  |   |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crownsville Vet Cem</b>                             |   | 20c. Location - City or Town, State<br><b>3-20-2007 Anne Arundel, Md.</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Carlton C. Douglas</b>  |  |  |   | 22. Name and Address of Facility<br><b>Carlton C. Douglas Funeral Service P.A. 1701 McCulloch St. Balto. Md. - 21217</b>                         |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MYOCARDIAL INFARCTION</b> |  |  |   |  |  |   |  |
|   | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>       |  |  |   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>  |   | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)</b><br><b>9 Unknown</b> |  |   |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SIGMOID VOLVULUS</b>   |   |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   | Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b>   |  | 26. Place of Death (Check only one)<br>Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28d. Describe how injury occurred   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Daniel Plotnick MD</b>  |   |  |  | 29c. License number<br><b>P21130</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAR 13 2007</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANIEL PLOTNICK 10 NORTH GREENE ST BALTIMORE MD 21201</b>  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |   |  |  |   |  |  |   |  |
| 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ECU

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2007 08120

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><u>Alan Maurice Long</u> |  | 2. Date of Death<br>Month <u>March</u> Day <u>12</u> Year <u>2007</u> |  | 3. Time of Death<br><u>2135 hrs</u> |
|--|--|---|--|-------------------------------------|

Funeral Director

|  |  |  |                                   |
|--|--|--|-----------------------------------|
| 4a. Facility Name (if not institution, give street and number)<br><u>3116 Harford Road</u> |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u> | 4c. County of Death<br><u>N/A</u> |
|--|--|--|-----------------------------------|

|   |  |  |  |  |  |   |
|---|--|--|--|--|--|---|
| 5. Social Security Number<br><u>213-70-0831</u> | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>49</u> Yrs. | If Under 1 Year<br>Months <u>  </u> Days <u>  </u> | If Under 24 Hrs.<br>Hours <u>  </u> Min. <u>  </u> | 8. Date of Birth (MM/DD/YYYY)<br><u>April 13, 1957</u> | 9. Birthplace (State or Foreign Country)<br><u>MD</u> |
|---|--|--|--|--|--|---|

|                             |  |   |  |
|-----------------------------|--|---|--|
| Usual Residence of Decedent |  | 10c. City, Town or Location<br><u>Baltimore</u> | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|-----------------------------|--|---|--|

|                         |                           |  |                               |   |
|-------------------------|---------------------------|--|-------------------------------|---|
| 10a. State<br><u>MD</u> | 10b. County<br><u>N/A</u> | 10e. Street and Number<br><u>3116 Harford Road</u> | 10f. Zip Code<br><u>21218</u> | 10g. Citizen of What Country?<br><u>USA</u> |
|-------------------------|---------------------------|--|-------------------------------|---|

|  |  |   |  |   |
|--|--|---|--|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: <u>  </u> | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u> |
|--|--|---|--|---|

|  |  |  |  |
|--|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12TH</u> College (1-4 or 5+) <u>  </u> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>DATA PROCESSOR</u> | 16b. Kind of Business/Industry<br><u>DATA PROCESSING</u> |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><u>William Long Sr.</u> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Marianne Johnson</u> |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><u>PEARL LONG THOMAS</u> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>34 CUTASS COURT EMEX MD, 21224</u> |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <u>  </u> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>METRO CREMATORY</u> | 20c. Location - City or Town, State<br><u>3-15-07 CATONSVILLE MD</u> |
|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 21. Signature of Funeral Service Licensee<br><u>GARY P. MARSH</u> |  | 22. Name and Address of Facility<br><u>270 FREDERICK AVE BALTIMORE MD 21224</u> |  |
|---|--|---|--|

Physician  
Medical Examiner

|  |  |   |
|--|--|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>Atherosclerotic cardiovascular disease</u> |  | Approximate Interval Between Onset and Death<br><u>  </u> |
|--|--|---|

|  |  |   |
|--|--|---|
| Immediate Cause (Final disease or condition resulting in death)<br><u>Atherosclerotic cardiovascular disease</u> |  | Due to (or as a consequence of):<br><u>  </u> |
|--|--|---|

|   |  |   |
|---|--|---|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>  </u> |  | Due to (or as a consequence of):<br><u>  </u> |
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| Due to (or as a consequence of):<br><u>  </u> |  | Due to (or as a consequence of):<br><u>  </u> |
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| Due to (or as a consequence of):<br><u>  </u> |  | Due to (or as a consequence of):<br><u>  </u> |
|---|--|---|

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><u>MAR 15 2007</u> | 32. Registrar's Signature<br><u>[Signature]</u> |
|---|---|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08121

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Allan Theodore Leffler, II

2. Date of Death  
Month Day Year  
March 5, 20073. Time of Death  
2250 hrs

4a. Facility Name (if not institution, give street and number)

Montgomery Rd &amp; Chatsworth Court

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

476.44.3574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

9/10/1940

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott city

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4790 Montgomery Rd.

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Doctor

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Allan Theodore Leffler

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Brown

19a. Informant's Name/Relationship (Type, Print)

Mrs. Melissa Leffler wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4790 Montgomery Rd. Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

3/12/07

20c. Location - City or Town, State

Balto., MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike, Ellicott City, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☒ AMENDED #5, per FH, 8866, 4/5/07 TT

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☒ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

Mar 5, 2007

28b. Time of Injury

2236 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver in auto auto collision

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Major Road / Highway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Montgomery Rd &amp; Chatsworth Court, Ellicott City, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 6, 2007

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 02122

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Elizabeth Mickins

2. Date of Death

3-3-07

3. Time of Death

10:30A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

110 North Central Ave Apt. 306

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

218-22-6046

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

4-15-23

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 North Central Ave Apt 306

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Eugene Logan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Crummie

19a. Informant's Name/Relationship (Type, Print)

Aloma Mickins - Duffy Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4042 The Alameda, Balto MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

3/9/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

13 in City M01363

22. Name and Address of Facility

Vaughan C. Greene Funeral Services 4905 York Rd. Balto MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Anemia

Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

13 in City M01363

29c. License number

D0059056

29d. Date signed (Month, Day, Year)

3/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dulcet Solaja 6821 Reisterstown Rd

Balt MD 21215

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Dulcet Solaja

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08123

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pernell McNeill

2. Date of Death

MAR 13 2007

3. Time of Death

1:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ST AGNES HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

219-52-9167

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-17-1949

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Kingston Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Computer Industry

17. Father's Name (First, Middle, Last)

Joseph McNeill

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Carter

19a. Informant's Name/Relationship (Type, Print)

Patrice Taylor / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4120 Tiverton Rd Randallstown MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn

Date

03-19-07

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Service  
8728 Liberty Road Randallstown MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ADENOCARCINOMA OF THE LUNG

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
YEARS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jibrin Dr.

29c. License number

P18619

29d. Date signed (Month, Day, Year)

MAR 13 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISMAILA JIBRIN ST. AGNES HOSPITAL, BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Informing Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08124

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna M. Mauchline

2. Date of Death

Month Day Year  
March 13 2007

3. Time of Death

1:15 P M

4a. Facility Name (If not institution, give street and number)

ManorCare Health Services

4b. City, Town, or Location of Death

Largo

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

168-10-8605

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 7, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16800 Clagett Landing Road

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Frank Kraus

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Eberhart

19a. Informant's Name/Relationship (Type, Print)

William C. Burkhardt / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16800 Clagett Landing Rd. Upper Marlboro, MD. 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sylvania Hills Cem.

Date

03/17/2007

20c. Location - City or Town, State

Rochester, PA.

21. Signature of Funeral Service Licensee

E Brian Powell

22. Name and Address of Facility

Beall Funeral Home  
6512 NW Crain Hwy. Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Mesothelioma - Pleura

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt; 1 month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alain Champaloux M.D.

29c. License number

D042049

29d. Date signed (Month, Day, Year)

March 14<sup>th</sup>, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alain Champaloux, M.D. 14314 Old Marlboro Pike Upper Marlboro, MD. 20772

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08125

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John S. Makulowich

2. Date of Death

March 11 2007

3. Time of Death

1148 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

141-34-5419

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

8. Date of Birth (Month, Day, Year)

December 9, 1943

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12008 Golden Twig Court

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Communications Director

16b. Kind of Business/Industry

National Institutes

Of Health

17. Father's Name (First, Middle, Last)

Alex Makul

18. Mother's Name (First, Middle, Maiden Surname)

Ann Bogdanowicz

19a. Informant's Name/Relationship (Type, Print)

Gail Makulowich /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12008 Golden Twig Court, N. Potomac, Maryland 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 15,

2007

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Angelita Barnett

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joel Bury, MD

29c. License number

D0064235

29d. Date signed (Month, Day, Year)

March 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Bury, MD 9901 Medical Center Drive, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Bryan H. Sparks

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08126

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Doris Lucy Myers</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> , Year <b>2007</b>        |   | 3. Time of Death<br><b>10:55 AM</b>              |   |  |   |  |   |  |  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>804 Clearview Avenue</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Hampstead</b>  |  | 4c. County of Death<br><b>Carroll County</b>  |  |   |  |   |  |  |  |  |  |
| 5. Social Security Number<br><b>212-50-0663</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>May 11, 1948</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |  | 10a. State<br><b>MD</b>   |  |   | 10b. County<br><b>Carroll</b>  |   |  | 10c. City, Town or Location<br><b>Hampstead</b>                         |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>804 Clearview Avenue</b>  |  |  | 10f. Zip Code<br><b>21074</b>   |  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |   |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Ink Lab Technician</b>  |  |   | 16b. Kind of Business/Industry<br><b>Malco Plastics</b>  |   |  |   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Percy Ward</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula Osborne</b>  |  |   |  |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Edward Myers, Son</b>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12622 Harewood Road, Middle River, MD 21220</b> |  |   |  |   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sam's Creek Church Cemetery</b>  |  |   | Date<br><b>03/14/2007</b>  |   | 20c. Location - City or Town, State<br><b>New Windsor, Maryland</b>  |   |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>T. Shuman</b> M01113   |  |  | 22. Name and Address of Facility<br><b>Harman Funeral Service, P.A.<br/>7221 Grayburn Drive, Glen Burnie, MD 21061</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>LUNG CA</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>6 years</b>   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |  |  |  |
|  |  |  |   |  |   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |  |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Flavio Kruter MD</b>   |  |  | 29c. License number<br><b>D35398</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>03-12-07</b>   |   |  |   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Flavio Kruter MD 555 South Center Street Westminster MD 21157</b>   |  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |  | Registrar's Signature<br><b>Flavio Kruter</b>   |  |   |  |   |  |   |  |  |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08127

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 12  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CONSTANCE OPEN</b>   |  | 2. Date of Death<br>Month <b>03</b> Day <b>14</b> Year <b>07</b>  |  | 3. Time of Death<br><b>6:25 PM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Hamilton</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>218-20-0855</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>05/01/1924</b> | 9. Birthplace (State or Foreign Country)<br><b>Minnesota</b>   |
| Usual Residence of Decedent   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>3111 Grindon Avenue</b>  |  | 10f. Zip Code<br><b>21214</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Physics Laboratory</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George B. German</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Archer</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard B. Oden, Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3111 Grindon Avenue, Baltimore, MD 21214</b>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Svc. Coroporation</b>  |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road, Baltimore, MD 21214</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Progressive Decline</b><br>Due to (or as a consequence of):<br>b. <b>Esophageal Stricture</b><br>Due to (or as a consequence of):<br>c. <b>Anaemia</b><br>Due to (or as a consequence of):<br>d. <b>Coronary Artery Disease</b>  |  |   |  |  |
| Approximate Interval Between Onset and Death  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Large Hiatal Hernia</b>  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D31464</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHOANIS A. HASHMI, MD, 821 N. EUTAW ST Suite 308 BALTIMORE MD 21201</b>  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  | 32. Registrar's Signature<br>   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- **Amend #10g per M 8865 3/19/07 JH** State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

Reg. No. **2007 08128**Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marilyn Pearce</b>  |  |   |  | 2. Date of Death<br>Month <b>3</b> Day <b>11</b> Year <b>07</b>  |  |  |  | 3. Time of Death<br><b>12:50 a.m.</b>                                   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  |  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |  |  |
| 5. Social Security Number<br><b>213-67-5640</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>10/28/1958</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Toronto, Canada</b>      |  |  |  |
| 10a. State<br><b>MD</b>  |  |   |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>8495 Spring Showers Way</b>   |  |   |  | 10f. Zip Code<br><b>21043</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA Canada</b>                      |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Murry Esson</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Corby</b>  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark Pearce/Husband</b>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8495 Spring Showers Way, Ellicott City, MD 21043</b> |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3/15/07 Catonsville, MD</b>  |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home @ MMP, Inc.<br/>7250 Washington Blvd., Elkridge, MD 21075</b>  |  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast cancer</b>   |  |   |  |  |  |  |  |   |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |   |  |  |  |
| 26. Place of Death Check only one<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>   |  |   |  |  |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |  |  |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day Year)  |  |   |  |  |  |  |  |   |  |  |  |
| 28b. Time of Injury<br>M   |  |   |  |  |  |  |  |   |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |   |  |  |  |
| 28d. Describe how injury occurred  |  |   |  |  |  |  |  |   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |  |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D0051926</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>March 11, 2007</b>            |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Helen M. Gordon 6565 N. Charles St Baltimore MD 21204</b>   |  |   |  |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08129

1- For State

Registrar

1. Decedent's Name (First, Middle, Last)

Shaun Michael Perry

2. Date of Death

March 9, 2007

Year

3. Time of Death

1146 hrs

4a. Facility Name (if not institution, give street and number)

19 Bratton Road

4b. City, Town, or Location of Death

Elton

4c. County of Death

Cecil

5. Social Security Number

590-30-5259

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

May 17, 1979

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

908 Patriots Way

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

Laborer

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Dean Lewis Perry

18. Mother's Name (First, Middle, Maiden Surname)

Candy Lynn Mierke

19a. Informant's Name/Relationship (Type, Print)

Dean Lewis Perry/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3615 Hurston St New Port Richey, FL 34655

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc

Date

3/13/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Methadone intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, 28a-f, per ME, g866, 4/17/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending Investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

Fnd 3/9/2007

28b. Time of Injury

Fnd 11:45 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) found in dwelling

28f. Location (Street and Number or Rural Route Number, City or Town, State)

19 Bratton Rd. Elkton, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mary G. Ripple MD.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 10, 2007

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2007 08130

1- For State Registrar

Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |  |  |  |  |
|--|---|--|---|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mamie D. Prouty</b>  |  |   |   | 2. Date of Death<br>Month <b>03</b> Day <b>14</b> Year <b>07</b>   |  |  |  | 3. Time of Death<br><b>6:00 a.m.</b>   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  |  |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-07-0755</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>December 5, 1910</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
|  | 10a. State<br><b>Maryland</b>   |  |   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                                      |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>Danier's 7610 Danier's Avenue</b>  |  |   |   | 10f. Zip Code<br><b>21234</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Clothing</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Gregorio Mugavero</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Salvatore Mugavero</b>   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Greg Prouty/Son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9206 Sandra Park Road Perry Hall Maryland 21128</b>  |  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer</b>   |   | Date<br><b>3/17/07</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>                     |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Christina A. Norton</b>   |  |   |   | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214</b>  |  |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Intra Cranial bleed</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 week</b>                                      |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute Renal failure</b><br><b>Sepsis</b><br><b>Seizures</b>  |  |   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |  |  |
| State Registrar  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |   | 29c. License number<br><b>D37612</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>03-14-07</b>                               |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Mohamad Alabrash 9000 Franklin Square Drive Baltimore, Md 21237</b> |   |  |   |   |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b> |  |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08131

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |   |
|---|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lillie B Phillips</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>7:00 PM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>7 Cobblestone Court Apt T1</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death  |   |
| 5. Social Security Number<br><b>216-40-2321</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>11-22-1939</b>   | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b> |
| Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>7 Cobblestone Court Apt T1</b>   |  |   |  | 10f. Zip Code<br><b>21215</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House keeping</b>  |                                | 16b. Kind of Business/Industry<br><b>Hotel</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Isiah Phillips</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Black</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline P. Wallace / daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3435 Gaither Road Baltimore, MD 21244</b>  |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Park</b>  |  | Date<br><b>03/17/2007</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>  |  |   |  | 22. Name and Address of Facility<br><b>Vaughn C. Greene Funeral Service<br/>8728 Liberty Road Randallstown MD 21133</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>VENTRICULAR ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of): |  |   |  |  |                                |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |                                | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>DIABETES MELLITUS</b>   |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Vaughn C. Greene MD</b>   |  | 29c. License number<br><b>MD 00046502</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARONW BARNSTEIN MD 1838 GUNN YR RD MD # 535 NAT MD 21208</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |                                |  |   |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 06132

1- For State Registrar

|  |  |  |   |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician / Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Katherine Rutsky</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>2007</b>  |  |  |   | 3. Time of Death<br><b>1615</b> M  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>119 East Cross Street</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |  |   | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral Director   | 5. Social Security Number<br><b>175-01-2693</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 21, 1915</b>       |   | 9. Birthplace (State or Foreign Country)<br><b>IL</b>  |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Charleroi</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>922 5th Street</b>  |  |   |  | 10f. Zip Code<br><b>15022</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                        |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Blasko</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Sima</b>  |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Rutsky / Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>119 East cross Street, Baltimore, MD 21230</b>   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery</b>  |  | Date<br><b>03/19/2007</b>  |  | 20c. Location - City or Town, State<br><b>Carroll Township, PA</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Dorothy W. Marshall</i>  |  |   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home Inc.<br/>1501 East Fort Avenue, Baltimore, MD 21230</b>   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br>a. <b>Potential for Medical Examiner</b><br>b. <b>CERTIFIED BY MEDICAL EXAMINER</b><br>c. <b>3 years</b><br>d. <b>Approximate Interval Between Onset and Death</b> |  |   |  |  |  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year    |  |   |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fractured ankle - Date uncertain</b>  |  |  |   |  |  |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No  |  |  |   |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |   |  |  |  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>November 2006</b><br>28b. Time of Injury<br><b>Unknown</b><br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br><b>Subject Fall</b><br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>residence</b><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>922 5th Street Charleroi PA</b> |  |  |   |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Ellen H. Kelly</i><br>29c. License number<br><b>020094</b><br>29d. Date signed (Month, Day, Year)<br><b>03/15/07</b>   |  |  |   |  |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (If not 23a) (Type, Print)<br><b>1411 Madison Park Drive, Glen Burnie, MD, 21061</b>   |  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b><br>32. Registrar's Signature<br><i>John B. Spiller</i>   |  |  |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08133

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Joseph Ryan

2. Date of Death

Month Day Year  
March 12 2007

3. Time of Death

9:40 A M

4a. Facility Name (If not institution, give street and number)

2915 Tapered Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

041-28-5362

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

8. Date of Birth (Month, Day, Year)

March 24, 1937

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2915 Tapered Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1959-62

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

U.S. Govt.

17. Father's Name (First, Middle, Last)

Thomas A. Ryan

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Ward

19a. Informant's Name/Relationship (Type, Print)

Nancy A. Ryan / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2915 Tapered Lane Bowie, MD. 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery

Date

03/16/2007

20c. Location - City or Town, State

Bowie, MD.

21. Signature of Funeral Service Licensee

E. Brian Powell

22. Name and Address of Facility

Beall Funeral Home  
6512 NW Crain Hwy. Bowie, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Esophagus cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

34 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Janine Werner

29c. License number

052830

29d. Date signed (Month, Day, Year)

March 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janine Werner, 9003 Berge Road #300, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Certificate of Death

Reg. No. 2007 08134

1- For State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Melissa Blake Rowny</b>  |  | 2. Date of Death<br>Month Day Year<br><b>March 11, 2007</b>   |  | 3. Time of Death<br><b>11:25 P<sup>M</sup></b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5329 Woodlawn Avenue</b>   |  | 4b. City, Town, or Location of Death<br><b>Chevy Chase</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>215-54-4730</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 26, 1948</b> | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Chevy Chase</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>5329 Woodlawn Avenue</b>   |  | 10f. Zip Code<br><b>20815</b>  |  |
| 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William T. Blake</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy L. Swisher</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Rowny / Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5329 Woodlawn Avenue, Chevy Chase, Maryland 20815</b>  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium Inc.</b>  |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><br><b>MO1433</b>   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Breast Cancer</b>  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Underlying cause is the event that initiated events resulting in death) Last  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D0033243</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Frederick P. Smith, M.D. 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |
| 32. Registrar's Signature<br>  |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Stewart Smith

2. Date of Death  
Month Day Year

MARCH 13 2007

3. Time of Death  
1540 M

Funeral Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-44-7199

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03-14-1945

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

625 N. Woodington Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

former

16b. Kind of Business/Industry

Cement

17. Father's Name (First, Middle, Last)

Matthew Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Rice

19a. Informant's Name/Relationship (Type, Print)

Shirley M. Smith (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

625 N. Woodington Rd., Baltimore, MD 21229

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

3/20/2007

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Services  
5151 Baltimore Nat'l Pike, Balto., MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PANCYTOPENIA

Due to (or as a consequence of):

c. NON HODGKINS LYMPHOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vaughn C. Greene, MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

MARCH 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANIA KASSEN 5610 LORRAVEN BLVD BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

MAR 13 2007

32. Registrar's Signature

[Signature]

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2007 08136

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>MALAKYAH V. SIRLEAF</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>2339 hrs</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Sinai Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death  |   |
| 5. Social Security Number<br><b>082-78-2137</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.   |   |
| 8. Date of Birth (MM/DD/YYYY)<br><b>Feb. 2, 1987</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>N.Y.</b>  |  |  |   |
| Usual Residence of Decedent   |  |  |  |  |   |
| 10a. State<br><b>Md.</b>  |  | 10b. County  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2819 Gatehouse Drive</b>  |  | 10f. Zip Code<br><b>21207</b>  |   |
| 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Disabled</b>   |  | 16b. Kind of Business/Industry<br><b>Disability</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Momolu Sirleaf, Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elouise Richardson</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Momolu Sirleaf, Sr./Father</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2819 Gatehouse Drive Baltimore, Md. 21207</b>  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, Md.</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Haron Johnsonalley</i>  |  | 22. Name and Address of Facility<br><b>Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Complications of Rett syndrome</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |  |  |  | Approximate Interval Between Onset and Death  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown   |  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other: |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                             |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Zabiullah Ali</i>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  | 32. Registrar's Signature<br><i>Kevin H. Smith</i>   |  |  |   |

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08137

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Alexander Sabo a.k.a. Lester Alexander Szabo

2. Date of Death

March 13, 2007

3. Time of Death

3:35 P. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

135-09-9122

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

June 21, 1910

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

New Jersey

10b. County

Middlesex

10c. City, Town or Location

Carteret

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

167 Randolph Street

10f. Zip Code

07008

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Post Master

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Alexander Szabo

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Kovacs

19a. Informant's Name/Relationship (Type, Print)

Barbara S. Hilberg / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5003 Acacia Ave., Bethesda, Maryland 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hungarian Reform Cemetery

Date

March 17, 2007

20c. Location - City or Town, State

Hopelawn, New Jersey

21. Signature of Funeral Service Licensee

Robert A. Humphrey

M00896

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc.

7557 Wisconsin Ave., Bethesda, MD 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal failure

Due to (or as a consequence of):

b. Bladder cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia, hypodemia

coronary atherosclerosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frauke Westphal

29c. License number

D0019785

29d. Date signed (Month, Day, Year)

March 14<sup>th</sup>, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frauke Westphal, M.D., 1201 Seven Lochs Road, Rockville, Maryland 20854

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08138

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pete Sotiropoulos

2. Date of Death

Month Day Year  
March 11, 2007

3. Time of Death

10:55 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

381-34-3422

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 1, 1934

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Ontario

10b. County

None

10c. City, Town or Location

Woodbridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

70 Sandys Drive

10f. Zip Code

L4L-3E3

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Ioannis Sotiropoulos

18. Mother's Name (First, Middle, Maiden Surname)

Katingo Christopoulos

19a. Informant's Name/Relationship (Type, Print)

Patricia Vranis / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9220 Marseille Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Elgin Mills Cemetery

Date

March 16,  
2007

20c. Location - City or Town, State

Toronto, Canada

21. Signature of Funeral Service Licensee

Angelle Parnot

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Myocardial Infarction

b. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
7 hours

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Sunil Saxena M.D.

29c. License number

D0057455

29d. Date signed (Month, Day, Year)

March 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Saxena, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08139

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Saylor Saul

2. Date of Death  
Month Day Year  
March 9, 20073. Time of Death  
11:00 AM

4a. Facility Name (If not institution, give street and number)

Future Care Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

579-10-9153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 16, 1918

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

305 College Parkway

10f. Zip Code

21012

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Doctor's Office

17. Father's Name (First, Middle, Last)

Horace Dodge Rouzer

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Barker Munroe

19a. Informant's Name/Relationship (Type, Print)

Janice S. Pusey / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3019 Belair Drive, Bowie, Maryland 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery

Crematorium, Inc.

Date

March 13,

2007

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01473

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Alzheimer's dementia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DS0725

29d. Date signed (Month, Day, Year)

3-9-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger 8601 Veterans Hwy M. U.S. 1108

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10g, 19b per FH 6865.3/15/07 WS

State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03140

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BERNICE

SIEGEL

2. Date of Death

MARCH

Day

11

Year

2007

3. Time of Death

12:50P

M

4a. Facility Name (If not institution, give street and number)

BRIGHTWOOD NURSING HOME

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

217-26-9373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

06/09/1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6521 GARDENWICK ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

OWNER

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

GREETING CARDS &amp; GIFTS

17. Father's Name (First, Middle, Last)

ABRAHAM

BERLIN

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE

MILLSTONE

19a. Informant's Name/Relationship (Type, Print)

SANDER A. SIEGEL / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6521 GARDENWICK ROAD - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH TFILOH CONG.

Date

03/13/2007

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOMYOPATHY, END STAGE

Approximate Interval Between Onset and Death

MONTHLY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

[Signature]

29c. License number

D25643

29d. Date signed (Month, Day, Year)

03/12/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENDALL FAULKNER MD - 6565 N. CHARLES STREET SUITE 209-BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per th 8865 3-13-07 vt

State of Maryland / Department of Health and Mental Hygiene

2007 08141

1- For State Registrar

Certificate of Death

Reg. No.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GLADYS SIEGEL</b>  |   | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> Year <b>07</b>   |  | 3. Time of Death<br><b>12:24</b> M   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Shaw Hospital of Baltimore</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral Director   | 5. Social Security Number<br><b>217-05-9689</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>04/22/1919</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   | 10. Usual Residence of Decedent   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b>   | 10c. City, Town or Location<br><b>REISTERSTOWN</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>14214 HANOVER PIKE</b>   |   | 10f. Zip Code   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |
|  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL WOLKOVSKY</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LINA FRANKLIN</b>  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LANA BARRICK / DAUGHTER</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14214 HANOVER PIKE - REISTERSTOWN, MD 21136</b> |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEBREW YOUNG MENS</b>  |  | 20c. Location - City or Town, State<br><b>WOODLAWN, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael Sugar</i>   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                         |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. Intracranial Hemorrhage</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) |   | 23d. Date of delivery<br>Month Day Year   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> , M.D.   |   | 29c. License number<br><b>RES-666</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March, 11, 07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hamed Mirach, M.D. Shaw Hospital of Baltimore</b>   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

When known as Siegel Gladys

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Ky.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08142

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARLYNE C. SCHMALBACH

2. Date of Death  
Month Day Year  
MARCH 10, 20073. Time of Death  
7:45 P.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CARROLL LUTHERAN VILLAGE

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

215-56-0307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

6/6/1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 ST. LUKE CIRCLE #306

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER'S AIDE

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

HARRY CHENOWETH

18. Mother's Name (First, Middle, Maiden Surname)

ELEANOR BRAUER

19a. Informant's Name/Relationship (Type, Print)

DR. WILMER L. JONES/SON-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 EDGERTON ROAD TOWSON, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LORRAINE PARK CEM.

Date

3/14/2007

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

*Heather P. Hay*

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Chronic obstructive pulmonary disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Death and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia*  
*Atrial fibrillation*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Kevin Brewster, D.O.*

29c. License number

H0055845

29d. Date signed (Month, Day, Year)

3/12/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN BREWSTER 1380 Regatta Way #106 21104

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

*Brian K. Smith*

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08143

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Albert L. Thornton, Sr.

2. Date of Death

Month

Day

Year

March 12, 2007

3. Time of Death

4:22 A M

4a. Facility Name (If not institution, give street and number)

Gilchrist Nursing Home

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

227-18-9603

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/31/1923

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5533 Belle Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Bench Operator

16b. Kind of Business/Industry

Armco Steel

17. Father's Name (First, Middle, Last)

Albert L. Thornton

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Holland

19a. Informant's Name/Relationship (Type, Print)

Lena Thornton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5533 Belle Ave Baltimore MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

3-21-2007

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Service  
8728 Liberty Road Randallstown MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Vascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vaughn C. Greene

29c. License number

D58303

29d. Date signed (Month, Day, Year)

March 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Armon J. Charles MD 6701 N. Charles St Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 15 2007

Registrar's Signature

Armon J. Charles

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No

2007 03144

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08145

1- For State Registrar

Physician/  
Medical Examiner

|   |   |                              |
|---|---|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>Robert W. Taylor, <del>SR</del> | 2. Date of Death<br>Month Day Year<br>March 4, 2007 | 3. Time of Death<br>0759 hrs |
|---|---|------------------------------|

Funeral  
Director

|  |  |  |
|--|--|--|
| 4a. Facility Name (if not institution, give street and number)<br>13707 Old National Pike Apt. C | 4b. City, Town, or Location of Death<br>Mount Airy                             | 4c. County of Death<br>Frederick                     |
| 5. Social Security Number<br>216-94-0264   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>40 Yrs.            |
| 8. Date of Birth (MM/DD/YYYY)<br>April 8, 1966   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |

To Be Completed by Funeral Director

|  |                          |  |  |  |
|--|--------------------------|--|--|--|
| Usual Residence of Decedent  |                          | 10c. City, Town or Location<br>Mt. Airy  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10a. State<br>Maryland   | 10b. County<br>Frederick | 10e. Street and Number<br>13707 Old National Pike, Apt. C  |  | 10f. Zip Code<br>21771   |
| 10g. Citizen of What Country?<br>United States   |                          | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced           |  |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)  |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Tree Climber  |  | 16b. Kind of Business/Industry<br>Tree Company   |

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>John H. Taylor, Sr. | 18. Mother's Name (First, Middle, Maiden Surname)<br>June L. Conaway |
|--|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>JoAnne L. Surber / Sister | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11865 Boyd Road, Clear Spring, Maryland 21722 |
|---|--|

|  |   |                        |   |
|--|---|------------------------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc | Date<br>March 12, 2007 | 20c. Location - City or Town, State<br>Bethesda, Maryland |
|--|---|------------------------|---|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br><i>Angela Barrow</i> M01305 | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br>300 West Montgomery Avenue, Rockville, Maryland 20850-2805 |
|--|---|

Physician  
/Medical  
Examiner

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Methadone intoxication<br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|---|--|

|   |  |
|---|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of): |  |
|---|--|

|                                     |  |
|-------------------------------------|--|
| c. Due to (or as a consequence of): |  |
|-------------------------------------|--|

|                                     |  |
|-------------------------------------|--|
| d. Due to (or as a consequence of): |  |
|-------------------------------------|--|

|  |  |
|--|--|
| <input checked="" type="checkbox"/> UNPENDED | <input checked="" type="checkbox"/> AMENDED<br>#1, 23a, PII, 27, 28a-f, per ME, g865, 3/20/07 TT |
|--|--|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|   |  |
|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cocaine use | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|---|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|---|

|   |  |                                    |   |  |
|---|--|------------------------------------|---|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>Fnd 3/4/2007 | 28b. Time of Injury<br>Fnd 7:30 am | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>unk |
|---|--|------------------------------------|---|--|

|   |   |
|---|---|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>found at home | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Mt. Airy, MD 13707 Old National Pike Apt. C |
|---|---|

|  |   |                                 |  |
|--|---|---------------------------------|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Patricia Aronica-Pollak</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>March 5, 2007 |
|--|---|---------------------------------|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
|---|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>MAR 15 2007 | 32. Registrar's Signature<br><i>Robert Taylor</i> |
|--|---|

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08146

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARJORIE ROSALIE TALESNIK

2. Date of Death

March 10 2007

3. Time of Death

4:50 PM

4a. Facility Name (If not institution, give street and number)

2408 SYLVALE ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

219-10-3970

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06/28/1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2408 SYLVALE ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LEGAL SECRETARY

16b. Kind of Business/Industry

LAW OFFICE

17. Father's Name (First, Middle, Last)

MEYER

18. Mother's Name (First, Middle, Maiden Surname)

GOLDBERG

SOPHIE

RUDO

19a. Informant's Name/Relationship (Type, Print)

DIANNE PASTERNAK / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2408 SYLVALE ROAD - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)ARLINGTON-CHIZUK  
AMUNO CONG.

Date

03/13/2007

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

*Michael B...*

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. PNEUMONIA  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 DAYS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

NORMAL PRESSURE HYDROCEPHALUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Bruce Rosenbergs*

29c. License number

D24121

29d. Date signed (Month, Day, Year)

3-10-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUCE ROSENBERG

21 WEST RD

TOWSON, MD 21204

31. Date filed (Month, Day, Year)

MAR 15 2007

Registrar's Signature

*Bruce Rosenbergs*State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

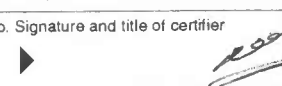


2007 08147

1- For State Registrar

Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |   |   |
|---|---|---|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sadie Eustace Vermilyea</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>March 10, 2007</b>  |  | 3. Time of Death<br><b>9:32 PM</b>                                      |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Potomac</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |  | 4c. County of Death<br><b>Montgomery</b>                                |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>061-10-7523</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>December 18, 1907</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |
|   | Usual Residence of Decedent   |   |   |  |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Bethesda</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|   | 10e. Street and Number<br><b>4821<br/>4820 Montgomery Lane #301</b>   |   |   | 10f. Zip Code<br><b>20814</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Dugan</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Connor</b>  |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gail Quigley / Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4820 Montgomery Lane #301, Bethesda, Maryland 20814</b>                                  |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | Date<br><b>March 15, 2007</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br><br><b>M01473</b>  |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.<br/>Bethesda, Maryland 20814-3501</b> |  |  |  |   |   |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>pneumonia</b>  |   |   |  | Approximate Interval Between Onset and Death   |  |   |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Advanced pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |   |  |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b>  |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | 26. Place of Death (Check only one)<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                           |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D0054566</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/11/07</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sukhtha Bhogavilli, 14702 Cherryleaf terrace, Silver Spring, MD 20906</b>  |   |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |   | 32. Registrar's Signature<br>  |   |  |  |  |   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,


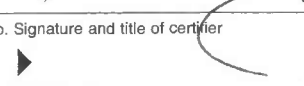
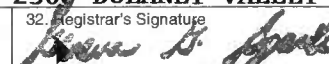
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08148

1- For  
State  
Registrar

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John B. Wallace III</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> , Year <b>2007</b>   |  | 3. Time of Death<br><b>5:18 A M</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-20-2069</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 29, 1927</b>                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Catonsville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>715 Maiden Choice Lane</b>  |  | 10f. Zip Code<br><b>21228</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1944</b><br>If Yes, Give Year or Dates: <b>1946</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banker</b>   |  | 16b. Kind of Business/Industry<br><b>Banking</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Lawson B. Wallace</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Freberger</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan S. Wallace, Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>715 Maiden Choice Lane Catonsville, Maryland 21228</b>                |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br><br><b>Thomas Gregor</b>   |  | 22. Name and Address of Facility<br><b>MacNabb Funeral Home, P.A.<br/>301 Frederick Road Catonsville, Maryland 21228</b>  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D43725</b>   | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00149

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Robert B. White, Sr.

2. Date of Death

Month Day Year  
March 11, 2007

3. Time of Death

0826 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

180-24-8435

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

OCT 17, 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

727 E. 22nd St

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 50-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Supervisor

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Garison White

18. Mother's Name (First, Middle, Maiden Surname)

Lorretta Rock

19a. Informant's Name/Relationship (Type, Print)

Robert B. White, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

518 S.Yewdall St Philadelphia, PA 19143

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc

Date

3/14/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b Due to (or as a consequence of):

c Due to (or as a consequence of):

d Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease, Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08150

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Rhunell Yates, Jr

2. Date of Death

MAR 13, 2007

3. Time of Death

3:15 A M

4a. Facility Name (If not institution, give street and number)

2603 East Chase St

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

249-58-8648

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 30, 1936

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2603 East Chase St

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse Foreman

16b. Kind of Business/Industry

Lumber Company

17. Father's Name (First, Middle, Last)

Joseph R. Yates, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rhunell Debois

19a. Informant's Name/Relationship (Type, Print)

Blondell Louise Yates/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2603 East Chase St Baltimore, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc

Date

3/13/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer

Approximate Interval Between Onset and Death

Oct 2001

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D53070

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital, 1650 Orleans St, Bk 11, MD 21231

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08151

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen F. Zakoscielna

2. Date of Death  
Month Day Year  
March 14, 20073. Time of Death  
7:00 A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Patricia Smith Assisted Living

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

5. Social Security Number

216-07-4719

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 11, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

812 South Milton Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Zakoscielna

18. Mother's Name (First, Middle, Maiden Surname)

Rose Czajkowski

19a. Informant's Name/Relationship (Type, Print)

Lillian Jozwiak - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7205 Gough St. Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Rosary Cem.

Date

3-16-07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

▶ Robert Prochazka

22. Name and Address of Facility

Kaczorowski Funeral Home, PA  
1201 Dundalk Ave. Baltimore, Md. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Approximate  
Interval Between  
Onset and Death  
OVER 5 YEARS

Due to (or as a consequence of):

b. ALZHEIMER'S DISEASE

OVER 5 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ Perfecto C. Valerao

29c. License number

D0016389

29d. Date signed (Month, Day, Year)

MARCH 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALERAO, M.D., 1716 HARFORD ROAD SU. 105 FALLSTON MD 21047

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

▶ [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
505A.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 00152

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Leroy Alvey</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>3:10A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Doctors Community Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>215-14-7008</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 21, 1920</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>5013 55th Avenue</b>   |  |   |  | 10f. Zip Code<br><b>20781</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fire Fighter</b>   |  | 16b. Kind of Business/Industry<br><b>US Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Alvey</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose E. Hancock</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda J. Young - Daughter/POA</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1915 Winding Ridge Trail, Knoxville, TN 37922</b>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>3/3/2007</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br>a. <b>Cerebrovascular accident</b><br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>Unknown</b> |  |   |  |  |  |  |  |
| 23b. If female, Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br> M.O.   |  |   |  | 29c. License number<br><b>D43446</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3.1.07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROINTAN FARAH (FAR M.O. 9801 Georgia Ave suit 3-41 Silver Spring MD 20902</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08153

1- For  
State  
Registrar

|   |  |  |   |  |   |  |   |  |  |  |  |  |
|---|--|--|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Claude Allen</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 17 2007</b>   |  |   |  | 3. Time of Death<br><b>1:40 PM</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctor's Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-82-2436</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 28, 1935</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>Jamaica, WI</b>                                 |  |  |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>5418 Gallatin Street</b>  |  |   |  | 10f. Zip Code<br><b>20781</b>   |  |   |  | 10g. Citizen of What Country?<br><b>Jamaica, WI</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>N/A</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>N/A</b>   |  |   |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Madeline Jones - Landlord</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5418 Gallatin Street, Hyattsville, MD 20781</b>   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | Date<br><b>03/03/07</b>   |  | 20c. Location - City or Town, State<br><b>Ellicott City, MD</b>                                |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ralph Williams</b>   |  |   |  | 22. Name and Address of Facility<br><b>Latney's Funeral Home<br/>3831 Georgia Avenue, NW, Washington, DC 20011</b>  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Disease of the Colon</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertensi-</b>   |  |   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>D 45060</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>2-16-07</b>  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dpinder Singh, M.D.<br/>19300, CALLENT FEX LN, #24 BELLE MAR 2071</b>   |  |   |  |   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08154

1- For  
State  
Registrar

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Alice Alfreda Anderson</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>March 1, 2007</b>  |  | 3. Time of Death<br><b>11:00p. M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>231-18-5723</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 20, 1924</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Beaver Creek</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>Route 3</b>  |  | 10f. Zip Code<br><b>21740</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>her own home</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Alfred L. Robinson</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Alice Hayslett</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sherry R. Boland - daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Post Office Box 435, Springfield, West Virginia 26763</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Frederick L. Venter</b>   |  |  |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 East Wilson Blvd., Hagerstown, Maryland 21740</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Chronic obstructive lung disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2 day</b><br><b>years</b> |  |  |  |   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Cynthia Kuttner-Sands, MD</b>   |  |  |  | 29c. License number<br><b>D47451</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 2, 2007</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cynthia Kuttner-Sands MD Williamsport Nursing Home, 154 North Artizan Street, Williamsport, Maryland</b>   |  |  |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  |  |  | 32. Registrar's Signature<br><b>James B. Sparks</b>   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08155

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irwin Axelrod

2. Date of Death

February 27, 2007

3. Time of Death

6:00 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

063-22-4865

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Aug. 10, 1930 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

NY

10b. County

Kings

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3033 Coney Island Ave. Apt. 2F

10f. Zip Code

11235

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Joseph Axelrod

18. Mother's Name (First, Middle, Maiden Surname)

Lena Hochfelson

19a. Informant's Name/Relationship (Type, Print)

Harold Axelrod/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 S. Belgrade Rd., Silver Spring, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Montefiore Cem

Date

2/28/2007

20c. Location - City or Town, State

Farmingdale, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

254 Carroll St., NW Washington, DC 20012  
Torchinsky Hebrew Funeral Home

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Pleural Effusion

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

Severe Peripheral Vascular Disease

Chronic Kidney Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D62949

29d. Date signed (Month, Day, Year)

02/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Natasha P. Haag M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Axelrod, Irwin 2/27/07 6:00AM

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08156

1- For  
State  
Registrar

|  |  |   |   |                                       |   |  |  |                                   |  |  |  |  |
|--|--|---|---|---------------------------------------|---|--|--|-----------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Betty Lou Adams</b>   |   |   |                                       | 2. Date of Death<br>Month Day Year<br><b>February 24, 2007</b>  |  |  |                                   | 3. Time of Death<br><b>4:05 p M</b>  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>13120 Fernedge Road</b>   |   |   |                                       | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |  |                                   | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-82-9609</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>82</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 28, 1925</b>        |                                   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |  |  |
|  | 10a. State<br><b>Maryland</b>  |   |   |                                       | 10b. County<br><b>Montgomery</b>  |  |  |                                   | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>13120 Fernedge Road</b>   |   |   |                                       | 10f. Zip Code<br><b>20906</b>   |  |  |                                   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                |  |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>  |   |   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |                                   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Erwin Rice</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Chambers</b>   |  |  |                                   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles F. Adams/ Son</b>   |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14111 Chelmsford Road, Rockville, MD 20853</b>  |  |  |                                   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |                                       | Date<br><b>Feb. 26, 2007</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |                                   |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Andrew J. Cole</b>   |   |   |                                       | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W., Silver Spring, MD 20901</b>  |  |  |                                   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Atrial Fibrillation</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>12 Years</b><br><b>12 Years</b> |   |   |                                       |   |  |  |                                   |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   |   |                                       | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown |  |  |                                   | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiomegaly, Hyperlipidemia, Invasive Ductal Carcinoma of Left Breast</b>  |   |   |                                       |   |  |  |                                   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                       |   |  |  |                                   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M              |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Wygammara, M.D.</b>   |   | 29c. License number<br><b>D 21662</b> |   | 29d. Date signed (Month, Day, Year)<br><b>2/26/07</b>                                |  |                                   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wilhelmina Camina, M.D. 4912 Adrian Street, Rockville, MD 20853</b>   |  |   |   |                                       |   |  |  |                                   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |                                       |   |  |  |                                   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08157

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George L. Adams, Jr.

2. Date of Death  
Month Day Year  
February 27 20073. Time of Death  
6:00 PM

4a. Facility Name (If not institution, give street and number)

5703 Phelps Luck Drive

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

219 38 6720

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 24, 1941

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5703 Phelps Luck Drive

10f. Zip Code

21045

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Customer Service Represent.

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

George L. Adams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Winfred Linde

19a. Informant's Name/Relationship (Type, Print)

Ellen J. Adams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5703 Phelps Luck Drive Columbia, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

2-28-2007

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Shen Collins - Witzke MO1044

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CARDIOMYOPATHY

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death  
1-2 DAYS

YEARS

YEARS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, HYPERTENSION, CHRONIC

KIDNEY DISEASE, HYPOTHYROIDISM, ATRIAL FIBRILLATION

SICK SINUS SYNDROME

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Shen Collins - Witzke

29c. License number

D 38296

29d. Date signed (Month, Day, Year)

February 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH GIBBONS MD 8186 LARKBROWN ROAD, SUITE 201, ELK RIDGE, MD 21075

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

K. H. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 02158

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

H.B. Bell

2. Date of Death  
Month Day Year

March 4, 2007

3. Time of Death  
M

1630

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hospice and Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

249-50-0840

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 9, 1934

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2416 Marbourne Ave. #2C

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Professional Trucker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Athel Bell

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Baxter

19a. Informant's Name/Relationship (Type, Print)

Renee Bell Anderson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Crawford Street  
Oxon Hill, Md. 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Mem. Cem. 3/9/07

Date

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

Renee Edwards

22. Name and Address of Facility

Hodges &amp; Edwards F.H.

3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. prostate cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DCA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Charles

29c. License number

D58303

29d. Date signed (Month, Day, Year)

March 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur J. Charles, MD 6701 N. Charles St Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Renee Edwards

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision or Vital Records, P.O. Box 68760, Up  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08159

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nelson Jeremiah Bowman

2. Date of Death

March 9, 2007

3. Time of Death

2157 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

216-12-9893

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Oct, 23, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4131 Webster Road

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Civil Servant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Warren N. Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Lenora Ely

19a. Informant's Name/Relationship (Type, Print)

Lenora Monteith (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 C York Woods Dr. Elkhart, Ind. 46516

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Churchville Presby. Cem.

Date

3/14/07

20c. Location - City or Town, State

Churchville, MD

21. Signature of Funeral Service Licensee

Kusken Amy Unglesbee

22. Name and Address of Facility

Tarring-Carjo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Systemic inflammatory response syndrome

Due to (or as a consequence of):

Wreospeas

Due to (or as a consequence of):

b. Bilateral epididymitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

24 hours

24 hours

? 48 hours

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II  
Coronary artery disease  
Possible acute myocardial infarction

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Brick, M.D.

29c. License number

D0036940

29d. Date signed (Month, Day, Year)

MARCH 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID C. BRICK, M.D.

HARFORD MEMORIAL HOSPITAL 301 SOUTH UNION AVENUE, HAVRE DE GRACE 21078

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

John B. Smith

State  
Registrar

ORIGINAL

NELSON BOWMAN  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

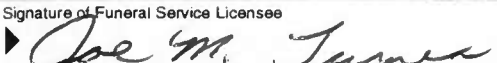

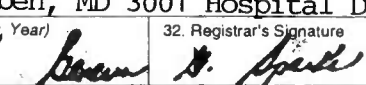
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08160

|  |   |  |   |  |  |  |
|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James C. Battle</b>  |  | 2. Date of Death<br>Month Day Year<br><b>February 27, 2007</b>  |  | 3. Time of Death<br><b>4:30 A M</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>238-64-7264</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 2, 1940</b> | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>New Carrollton</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>8311 Oliver Street</b>   |  | 10f. Zip Code<br><b>20784</b>   |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Contractor</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Douglas Battle</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Almeta Robinson</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Yvonne Battle</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8311 Oliver Street, New Carrollton, MD 20784</b>  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Riverdale Park Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3-2-07 Riverdale, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Bonnette &amp; Assoc. Funeral Home Inc. 2504 28th St., N.E., WDC 20018</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of): |  |   |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis -Congestive Heart Failure</b><br><b>Pneumonia</b><br><b>Pulmonary Hypertension</b> |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br><br><b>Patricia Eben MD</b>   |  | 29c. License number<br><b>D0057636</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 27, 2007</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patricia Eben, MD 3001 Hospital Dr., Cheverly, MD 20785</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |   | 32. Registrar's Signature<br> |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-698-2000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03161

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi Blumberg

2. Date of Death

Month Day Year  
February 27, 2007

3. Time of Death

4:47P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7403 Baltimore Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

335-40-9747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 15, 1914

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State  
MD10b. County  
Montgomery10c. City, Town or Location  
Takoma Park10d. Inside City Limits  
☒ Yes 2 ☐ No

10e. Street and Number

7403 Baltimore Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

United states

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Herman

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Boris

19a. Informant's Name/Relationship (Type, Print)

Carol H. Sweig - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7403 Baltimore Avenue Takoma Park MD 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Memorial Park Cemetery 3/2/07

Date

20c. Location - City or Town, State

Skokie, IL

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Danzansky-Goldberg Memorial

Chapel Inc 1170 Rockville Pike Rockville MD

20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Chronice Obstructive Pulmonary Disease

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Cynthia M Williams DO

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

2-28-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams DO Montgomery County Hospice 6001 Muncaster Mill Road  
Rockville MD 20855State  
Registrar

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08162

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles A. Bervine

2. Date of Death

February 28, 2007

3. Time of Death

4:20 a M

4a. Facility Name (If not institution, give street and number)

Genesis Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

128-16-5998

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 14, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1010 Stirling Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Carrier

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Robert Lee Bervine

18. Mother's Name (First, Middle, Maiden Surname)

Judith Muse

19a. Informant's Name/Relationship (Type, Print)

Yvonne Roberts/ Step-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 Stirling Road, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Plain Lawn Cemetery

Date

March 5,

2007

20c. Location - City or Town, State

Hicksville, New York

21. Signature of Funeral Service Licensee

James E. Dadey

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd, W., Silver Spring, MD 20901

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ghousia Sultana

29c. License number

D56691

29d. Date signed (Month, Day, Year)

February 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghousia Sultana, M.D. 12107 Heritage Park Circle, Silver Spring, MD 20906

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08163

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Dorothea Adeline Bell   |  | 2. Date of Death<br>Month Day Year<br>February 25, 2007   |   | 3. Time of Death<br>4:20 a M   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Rehab. & Nursing Center  |  | 4b. City, Town, or Location of Death<br>Burtontsville   |   | 4c. County of Death<br>Montgomery  |  |
| 5. Social Security Number<br>378-10-4628  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>88 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>May 25, 1918 | 9. Birthplace (State or Foreign Country)<br>Michigan   |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br>Maryland  | 10b. County<br>Montgomery  | 10c. City, Town or Location<br>Silver Spring  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br>10000 Brunswick Avenue, #426  |  | 10f. Zip Code<br>20910  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Hairdresser   |  |
| 16b. Kind of Business/Industry<br>Beauty Salon  |  | 17. Father's Name (First, Middle, Last)<br>Francis Cornelius Leahy  |   | 18. Mother's Name (First, Middle, Maiden Sumame)<br>Marguerite Matilda McKnight  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Daniel L. Maloney/ Cousin   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11531 Cushman Road, Rockville, MD 20852  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Mary Cemetery   |   | 20c. Location - City or Town, State<br>March 6, 2007 Evergreen Park, IL  |  |
| 21. Signature of Funeral Service Licensee<br>Epi S. Scerbo  |  | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home Inc.<br>500 University Blvd, W, Silver Spring, MD 20901   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive heart failure<br>Due to (or as a consequence of):<br>b. Severe Aortic Regurgitation<br>Due to (a. as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |  | 29c. License number<br>D0054566   |   | 29d. Date signed (Month, Day, Year)<br>2/26/07   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Suhitha Bhogavili, 1220 A East JOPPA ROAD, SUITH 230, TOLSON, MD 21286.   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 01 2007  |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08164

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ELIZABETH BODMER

2. Date of Death

MARCH 1 2007

3. Time of Death

8:10 A M

4a. Facility Name (If not institution, give street and number)

8121 GLENDALE DRIVE

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

577-42-6661

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 20 1930

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8121 GLENDALE DRIVE

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life - DO NOT use retired)GRAPHIC DESIGN  
COORDINATOR

16b. Kind of Business/Industry

ABC NEWS

17. Father's Name (First, Middle, Last)

CHARLES M. TIPTON

18. Mother's Name (First, Middle, Maiden Surname)

SARAH ELIZABETH WHITE

19a. Informant's Name/Relationship (Type, Print)

THOMAS BODMER / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17812 ELGIN RD., POOLESVILLE, MD 20837

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

STAUFFER CREMATOR, 3/2/07

Date

20c. Location - City or Town, State

FREDERICK, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HILTON FUNERAL HOME  
P.O. BOX 86, BARNESVILLE, MD 20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STAGE IV NON SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 MONTHS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0056314

29d. Date signed (Month, Day, Year)

MARCH 2ND 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINDU GEORGE 46 B THOMAS JOHNSON DRIVE FREDERICK MD 21702

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08165

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>KEITH ERIC BUCKALEW</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>02 19 07</b>   |  | 3. Time of Death<br><b>9:40 A. M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>WMHS BRADDOCK CAMPUS</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| 5. Social Security Number<br><b>218-68-2547</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1971</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Frostburg</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>20113 National Highway, S.W.</b>   |  | 10f. Zip Code<br><b>21532-</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>disabled</b>  |  | 16b. Kind of Business/Industry<br><b>none</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Buckalew</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Regina McKenzie</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Regina Buckalew mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20113 National Highway Frostburg Maryland 21532</b>                                       |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Finzel Cemetery</b>  |  | 20c. Date<br><b>February 22, 2007</b>   |  | 20d. Location - City or Town, State<br><b>Finzel Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>John R. Durst</i>  |  |   |  | 22. Name and Address of Facility<br><b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Endstage Chronic Lung Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>2 yrs</b>   |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Gary Wagoner</i>   |  |   |  | 29c. License number<br><b>D22181</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 19, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Wagoner, M.D. 925 Bishop Walsh Road, Cumberland, MD 21502</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 21 2007</b>  |  |   |  | 32. Registrar's Signature<br><i>Kevin B. Spivey</i>   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08166

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose U. Cantor

2. Date of Death  
Month Day Year  
February 25, 20073. Time of Death  
8:45 P M

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

072-01-9499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

8. Date of Birth (Month, Day, Year)

Sept 9, 1914

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

708 Bonifant St

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Camp Director

16b. Kind of Business/Industry

Recreational Day Camp

17. Father's Name (First, Middle, Last)

Harry Uslan

18. Mother's Name (First, Middle, Maiden Surname)

Anna Matilda Kahan

19a. Informant's Name/Relationship (Type, Print)

Ken Cantor/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Bonifant St, Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sharon Gardens

Date

Feb 28, 2007

20c. Location - City or Town, State

Vahalla, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic Breast Cancer

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0064871

29d. Date signed (Month, Day, Year)

2-25-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mina Fazli, MD 18111 Prince Philip Dr, #101, Olney, MD 20832

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08167

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH LEE CANTLER

2. Date of Death

February 26<sup>th</sup> 2007 6:27 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

213-40-9487

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

8. Date of Birth

NOV. 9, 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

KEEDYSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4127 TREGO MOUNTAIN ROAD

10f. Zip Code

21756

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER &amp; OPERATOR

16b. Kind of Business/Industry

CLEANING COMPANY

17. Father's Name (First, Middle, Last)

DELMORE CHARLES CANTLER

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE ELIZABETH THOMPSON

19a. Informant's Name/Relationship (Type, Print)

CAROL E. CANTLER/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4127 TREGO MOUNTAIN ROAD, KEEDYSVILLE, MD 21756

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESTHAVEN MEM GARDEN

Date

3/02/2007

20c. Location - City or Town, State

FREDERICK, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

b. Uncontrolled Hypertension

Due to (or as a consequence of):

c. Hypertensive Emergency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 40228

29d. Date signed (Month, Day, Year)

Feb 27 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Ahmed 12821 Oak Hill Ave Hagerstown Maryland 21742

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Karen B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08168

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FLORA ALMA CONNOR

2. Date of Death

Month Day Year  
02 27 2007

3. Time of Death

2200 M

4a. Facility Name (If not institution, give street and number)

WMHS-BRADDOCK CAMPUS

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

217-14-4902-A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

03/06/1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

235 Paca Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Harvey

Earl

Miller

18. Mother's Name (First, Middle, Maiden Surname)

Bertha

Sophia

Barnhart

19a. Informant's Name/Relationship (Type, Print)

George F. Connor / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1535 Sappington Drive, Gambrills, MD 21054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Mem. Gardens

Date

03/03/2007

20c. Location - City or Town, State

LaVale, MD

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis syndrome  
Due to (or as a consequence of):Approximate Interval Between Onset and Death  
2 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wonsock Shin MD

29c. License number

D0055325

29d. Date signed (Month, Day, Year)

Feb 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN MD 48 Taun Terrace Frostburg MD 21532

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08169

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Amy Griffith Crook

2. Date of Death

February 26, 2007

3. Time of Death

05:45 PM

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

218-46-4266

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

8. Date of Birth (Month, Day, Year)

Sept. 26, 1945 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Lewes

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

50 Lakewood Drive

10f. Zip Code

19958

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

William G. Jack V

18. Mother's Name (First, Middle, Maiden Surname)

Lora Greene

19a. Informant's Name/Relationship (Type, Print)

Harvey R. Jack / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8863 Turkey Point Road, North East, Maryland 21901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mayerdale Crematory

Date

February

20c. Location - City or Town, State

Newark, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cirrhosis of liver

Due to (or as a consequence of):

b. Multi-organ failure.

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d. Fungemia.

Approximate  
Interval Between  
Onset and Death

unknown

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0026183

29d. Date signed (Month, Day, Year)

2-27-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madhu Sachdev, M.D. 322 E Cecil Ave, North East, md 21901

31. Date filed (Month, Day, Year)

MAR 2 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08170

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Wilford Council Chase

2. Date of Death

February 27 2007

3. Time of Death

11:40 AM

4a. Facility Name (If not institution, give street and number)

Berlin Nursing Home

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

212-44-6366

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12 16 1943

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9004 West Biscayne DR

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Computer Consultant

16b. Kind of Business/Industry

Computers

17. Father's Name (First, Middle, Last)

Thomas C. Chase, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Jean Council Chase

19a. Informant's Name/Relationship (Type, Print)

Laura Chase Conner (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Crescent DR, Mountain Lakes, NJ 07046

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cape Henlopen Crem.

Date

2/28/2007

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home

108 William ST, Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or chain of.

Immediate Cause (Final disease or condition resulting in death)

a. Splenic Lymphoma

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28769

29d. Date signed (Month, Day, Year)

2/28/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Bondeau, MD 209 Convent Hwy New York, NY 10014

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

James H. Smith

Chase, Council W.  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

BA 2

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08171

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Agnes Callaway

2. Date of Death

February 27 2007

3. Time of Death

9:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6150 Foreland Garth Apt 517

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

453 07 2727

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 15, 1908

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6150 Foreland Garth Apt 517

10f. Zip Code

21045

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William F. Skelley

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Gilroy

19a. Informant's Name/Relationship (Type, Print)

Ellene C. Barnes/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5564 Nettlebed Court Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cemetery 3-3-2007

Date

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

M01044

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Francis Bruno MD

29c. License number

D0009526

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS BRUNO, M.D. Medical Arts Building, Columbia, MD 21044

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Francis Bruno

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08172

1- For State Registrar Amended # 2, per ME, 3/2/07 Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last) WILLIAM R. DUCK IV  
2. Date of Death Month Day Year February 24, 2006  
3. Time of Death 0225 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Shock Trauma University Hospital  
4b. City, Town, or Location of Death Baltimore  
4c. County of Death

5. Social Security Number 228-37-2563  
6. Sex 1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday) 21 Yrs.  
8. Date of Birth (MM/DD/YYYY) 06-29-1985  
9. Birthplace (State or Foreign Country) VA

Usual Residence of Decedent

10a. State MD  
10b. County  
10c. City, Town or Location BALTIMORE  
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 3306 W. FOREST PARK AVENUE  
10f. Zip Code 21216  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No specify:  
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT  
16b. Kind of Business/Industry EDUCATION

17. Father's Name (First, Middle, Last) WILLIAM R. DUCK III  
18. Mother's Name (First, Middle, Maiden Surname) PATRICIA PEGRAM

19a. Informant's Name/Relationship (Type, Print) PATRICIA CHASE - MOTHER  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 3306 W. FOREST PARK AVE., BALTIMORE, MD

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:  
20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATIONAL PARK  
20c. Date 03-02-07  
20d. Location - City or Town, State LAUREL, MARYLAND

21. Signature of Funeral Service Licensee Ronald Taylor, II  
22. Name and Address of Facility RONALD TAYLOR, II FUNERAL HOME 108 W. NORTH AVENUE, BALTIMORE, MD

Physician  
Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a Multiple stab wounds  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED ☒ AMENDED #4a, per ME, g865, 3/15/07 TT

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown  
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death 1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury Month Day Year Feb 24, 2007  
28b. Time of Injury 0000 hrs  
28c. Injury at Work? 1 ☐ Yes 2 ☒ No  
28d. Describe how injury occurred Subject stabbed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street  
28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 South Fulton Avenue, Baltimore, MD

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier Theodore M. King, Jr., MD  
29c. License number O.C.M.E.  
29d. Date signed (Month, Day, Year) February 24, 2007

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) MAR 02 2007  
32. Registrar's Signature

State  
Registrar

Baltimore, MD 21215-0036  
Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21201-0876  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21201-0876

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08173

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Raul Alfredo Duran

2. Date of Death

Month Day Year  
February 25, 2007

3. Time of Death

0915 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

4001 Oglethorpe Street

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

none

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

Feb. 3, 1978

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4001 Oglethorpe Street

10f. Zip Code

20782

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No specify: Salvadoran

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Alfredo Antonio Medina

18. Mother's Name (First, Middle, Maiden Surname)

Reyna Catalina Duran

19a. Informant's Name/Relationship (Type, Print)

Reyna Catalina Duran (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4001 Oglethorpe St. Hyattsville, Md. 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

Mar. 8, 2007

20c. Location - City or Town, State

El Salvador

21. Signature of Funeral Service Licensee

Wanda C. Bacon CC361

22. Name and Address of Facility

W. H. Bacon Funeral Home, Inc.  
3447 14th Street, NW Washington, DC 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Feb 25, 2007

28b. Time of Injury

FOUND: 0850 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged himself

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4001 Oglethorpe Street, Hyattsville, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

Ling Li, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 26, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Raul A. Duran

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08174

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Elizabeth DUTROW

2. Date of Death

March 3, 2007

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

212 Maple Avenue

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-12-1967

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 10, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

212 Maple Avenue

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

laundry worker

16b. Kind of Business/Industry

nursing home

17. Father's Name (First, Middle, Last)

Albert Drury

18. Mother's Name (First, Middle, Maiden Surname)

Lula Davis

19a. Informant's Name/Relationship (Type, Print)

Katherine E. Miller - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10802 Donaldson Drive, Williamsport, Maryland 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Boonsboro Cemetery

Date

March 7, 2007

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

Fried L. Vestal

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. gallbladder cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R MD

29c. License number

D58195

29d. Date signed (Month, Day, Year)

03/05/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tuba, MD 1138 Opal Ct. Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Beverly H. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 03175

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Freda

May

Dolan

2. Date of Death

Month

Day

Year

February 17, 2007

11:10 P<sup>M</sup>

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lions Center for Rehab. &amp; Ext. Care

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

705-05-5183

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

06/12/1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1701 Bedford Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Cleveland

William

Wigfield

18. Mother's Name (First, Middle, Maiden Surname)

Lula

Jane

Bucy

19a. Informant's Name/Relationship (Type, Print)

Joan K. Cosgrove / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

84 Eleanor Street, LaVale, Maryland 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

02/21/2007

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Robert C. Pelaez

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive Heart Failure

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wonsock Shin MD.

29c. License number

# D55325

29d. Date signed (Month, Day, Year)

February 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wonsock Shin, MD 48 Tarn Terrace Frostburg, MD 21532

31. Date filed (Month, Day, Year)

FEB 20 2007

32. Registrar's Signature

Robert C. Pelaez

State  
Registrar

Dolan, Freda M.  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

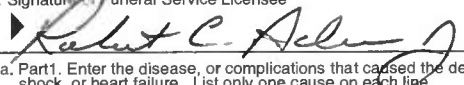
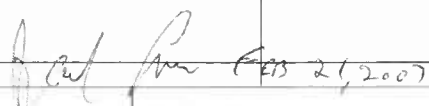
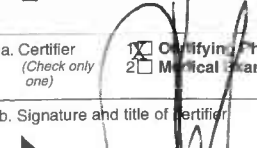
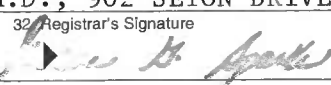
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08176

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                |  |  |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>David Wayne Dennison   |  |   |   | 2. Date of Death<br>Month FEBRUARY Day 20TH, Year 2007   |                                | 3. Time of Death<br>19:27 M  |  |
| 4a. Facility Name (If not institution, give street and number)<br>MEMORIAL HOSPITAL  |  |   |   | 4b. City, Town, or Location of Death<br>CUMBERLAND   |                                | 4c. County of Death<br>ALLEGANY  |  |
| 5. Social Security Number<br>212-84-6939   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>37 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>06/20/1969  |  |
| 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |   |  |                                |  |  |
| Usual Residence of Decedent  |  |   |   |  |                                |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Cumberland  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>20 Detroit Drive   |  |   |   | 10f. Zip Code<br>21502   |                                | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:             |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 1   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Taxi Driver   |                                | 16b. Kind of Business/Industry<br>Transportation   |  |
| 17. Father's Name (First, Middle, Last)<br>William P. Dennison, Sr.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Shelbea J. Cox  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>William P. Dennison, Sr. /father   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20 Detroit Drive, Cumberland, MD 21502  |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hillcrest Mem. Park   |   | Date<br>02/24/2007   |                                | 20c. Location - City or Town, State<br>Cumberland, MD  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARDIAC ARRHYTHMIA<br>Due to (or as a consequence of):<br>b. SEVERE METABOLIC ACIDOSIS RENAL FAILURE<br>Due to (or as a consequence of):<br>c. SYSTEMIC INFLAMMATORY SYNDROME<br>Due to (or as a consequence of):<br>d. MASSIVE RETROPERITONEAL HEMATOMA<br>Approximate Interval Between Onset and Death<br> |  |   |   |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>02/20/2007  |   | 28b. Time of Injury<br>1330 P M  |                                | 28c. Injury at Work?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>Canal Parkway-Cumberland, MD  |   | 28d. Describe how injury occurred<br>Taxi cab driver was driving taxi (Motor vehicle crash)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Canal Parkway, Cumberland, MD |                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician<br>2 <input type="checkbox"/> Medical Examiner   |  | 29b. Signature and title of certifier<br>  |   |  |                                |  |  |
|  |  | 29c. License number<br>D23167   |   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 20TH, 2007   |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ARRISUENO, JUAN A., M.D., 902 SETON DRIVE, SUITE 205, CUMBERLAND, MD 21502   |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 22 2007   |  | 32. Registrar's Signature<br>  |   |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Jls

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08177

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CHARLES LEONARD DOUGAREE, JR

2. Date of Death

Month Day Year  
FEBRUARY 27, 2007

3. Time of Death

7:40 AM

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

220-38-6689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

8. Date of Birth (Month, Day, Year)

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

SEPTEMBER 19, 1941

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CHESTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

100 PILOT COURT

10f. Zip Code

21619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MACHINIST

16b. Kind of Business/Industry

INDUSTRIAL

17. Father's Name (First, Middle, Last)

CHARLES L. DOUGAREE, SR

18. Mother's Name (First, Middle, Maiden Surname)

AUDREY MCGUIGAN

19a. Informant's Name/Relationship (Type, Print)

BETTY LOUISE DOUGAREE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 PILOT COURT, CHESTER, MARYLAND 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHESAPEAKE CREMATION

Date

MARCH 1,  
2007

20c. Location - City or Town, State

STEVENSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

C. H. H. H.

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.  
106 SHAMROCK ROAD, CHESTER, MARYLAND 2161923a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown  
3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Weinstein MD

29c. License number

1038445

29d. Date signed (Month, Day, Year)

02/27/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Weinstein 600 Ridgely Ave, Annapolis, MD

State  
Registrar

31. Date filed (Month, Day, Year)

MAR - 1 2007

32. Registrar's Signature

James H. Spinks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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/Medical  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

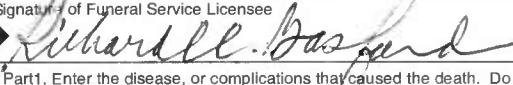
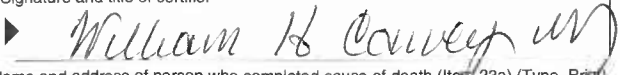

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08178

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Arthur Eiker</b>  |  |   |  | 2. Date of Death<br>Month: <b>March</b> Day: <b>11</b> Year: <b>2007</b>   |  |   |  | 3. Time of Death<br><b>9:00 AM M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>United Cerebral Palsy Residence</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  |   |  | 4c. County of Death<br><b>Frederick</b>   |  |  |  |
| 5. Social Security Number<br><b>214-82-6294</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 24, 1957</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  |   |  | 10b. County<br><b>Frederick</b>  |  |   |  | 10c. City, Town or Location<br><b>Frederick</b>   |  |  |  |
| 10e. Street and Number<br><b>6791 Sunnybrook Drive</b>   |  |   |  | 10f. Zip Code<br><b>21702</b>  |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |
| 11. Marital Status<br><b>XX</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>XX</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>XX</b> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>9</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never worked</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>None</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter C. Eiker</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jean Frances Angleberger</b>   |  |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Jean F. Eiker, mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6791 Sunnybrook Drive, Frederick, MD 21702</b>   |  |   |  |   |  |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  |   |  | 20c. Location - City or Town, State<br><b>Frederick, MD</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Keeney and Basford PA Funeral Home</b><br><b>106 East Church St., Frederick, MD 21701</b>   |  |   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Adult Failure to Thrive</b><br><b>Cerebral Palsy</b>  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 months</b><br><b>from Birth</b>   |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No<br><b>9</b> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown      |  |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Mental Retardation, uncontrolled seizures</b>   |  |   |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>UCP Home</b> |  |   |  |   |  |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  |   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>                             |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  | 28d. Describe how injury occurred                            |  |
|  |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D 20395</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William H. Convey, M.D., 195 Thomas Johnson Drive, Frederick, MD 21702</b>  |  |   |  |  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>  |  |   |  | Registrar's Signature<br>   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08179

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEROME EDWARD FOWLER, SR.

2. Date of Death

Month Day Year  
FEBRUARY 22, 2007

3. Time of Death

12:42 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

578-50-1201

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/04/1937

9. Birthplace (State or Foreign Country)

WASHINGTON D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CALVERT

10c. City, Town or Location

HUNTINGTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3830 HUNTING CREEK ROAD

10f. Zip Code

20639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SHIFT SUPERVISOR

16b. Kind of Business/Industry

MAILING  
INDUSTRY

17. Father's Name (First, Middle, Last)

RICHARD JEROME FOWLER

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE BERNICE DALTON

19a. Informant's Name/Relationship (Type, Print)

MARIAN E. FOWLER / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3830 HUNTING CREEK ROAD, HUNTINGTOWN, MARYLAND 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MARYLAND NATIONAL

Date

02/27/2007

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

P. K. King

22. Name and Address of Facility

ROBERT E. EVANS FUNERAL HOME,  
16000 ANNAPOLIS ROAD, BOWIE, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Myocardial Infarction

Approximate Interval Between Onset and Death

10 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

GI bleed

24 hours

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cindy Lee, MD

29c. License number

P19760

29d. Date signed (Month, Day, Year)

February 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cindy Lee 22 South Green Street Baltimore, MD 21201 Department of Medicine

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08180

1- For  
State  
Registrar

|  |  |   |  |  |  |   |   |  |  |
|--|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CLARA FREEMAN</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 25, 2007</b> |   | 3. Time of Death<br>Day Month Year<br><b>5:15 A M</b>       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Hebrew Home of Greater Washington</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>       |   | 4c. County of Death<br><b>Montgomery</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>167-01-2868</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 10, 1915</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                               |   | 10c. City, Town or Location<br><b>Rockville</b>             |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6121 Montrose Road</b>  |  | 10f. Zip Code<br><b>20852</b>   |   | 10g. Citizen of What Country?<br><b>U. S. A.</b> |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 Years</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales</b>   |  | 16b. Kind of Business/Industry<br><b>Shoes</b>   |  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ben Shulman</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Joseph</b>  |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara A. Rubin - Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2429 McCormick Road, Rockville, Md. 20850</b>  |  |   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Temple Sinai Mem Pk.</b>   |  | Date<br><b>2/28/2007</b>   |  | 20c. Location - City or Town, State<br><b>Plum Township, PA.</b>                                |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald C. Stettin</b>  |  | 22. Name and Address of Facility<br><b>Danzansky-Goldberg Memorial Chapels, Inc.</b>  |  | 1170 Rockville Pike, Rockville, Maryland 20852   |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ARTERIAL HYPERTENSION</b>   |  | Due to (or as a consequence of):<br><b>SENILE DEMENTIA</b>  |  |  |  | Approximate Interval Between Onset and Death  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Due to (or as a consequence of):  |  |  |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Barbara A. Rubin M.D.</b>   |  | 29c. License number<br><b>D35436</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 25, 2007</b>                                 |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BARBARA KAMZNY, 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  | 32. Registrar's Signature<br><b>Ann K. Smith</b>   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08181

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Phyllis Lorraine Fink

2. Date of Death

Month Day Year

March 1 2007 8:57 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

216-22-2085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9 1927

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11906 Heather Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

waitress

16b. Kind of Business/Industry

food services

17. Father's Name (First, Middle, Last)

Frank Lester Divelbiss

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice D. Weller

19a. Informant's Name/Relationship (Type, Print)

Linda Patterson daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21705 Chesnut Ridge Lane Hagerstown, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Paul Cemetery

Date

March 5,

2007

20c. Location - City or Town, State

Clear Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald Edwin Thompson Funeral Home, Inc

P.O. Box 310 Clear Spring, MD 21722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Due to (or as a consequence of):

pulmonary edema

b. Due to (or as a consequence of):

pulmonary fibrosis

c. Due to (or as a consequence of):

chronic obstructive pulmonary disease

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

6-8 hours

20+ years

30+ years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN

Parkinson's disease

Renal insufficiency

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-0056413

29d. Date signed (Month, Day, Year)

03/02/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Preethi Saxena MD, 1138 Opal Ct. Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Karen B. Sparks

State

Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division or Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08182

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Victoria Freeland

2. Date of Death

March 1, 2007

3. Time of Death

1:50 A M

4a. Facility Name (If not institution, give street and number)

Devlin Manor Health Care Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

213-22-3966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06/10/1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

701 E. Fourth Street, Apt. 303

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William G.

Miller

18. Mother's Name (First, Middle, Maiden Surname)

Mary M.

Breighner

19a. Informant's Name/Relationship (Type, Print)

Dorothy L. Duncan / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

701 E. Fourth St., Apt 303, Cumberland, MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cumberland Crematory 03/01/2007

Date

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AFIBRILLATION, HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0054004

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

hds

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08183

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR W. FRALEY

2. Date of Death

Month Day Year  
FEBRUARY 25 2007

3. Time of Death

11:45P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6000 Granby Road-Sycamore Acres

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

5. Social Security Number

191-14-9956

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 7 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17800 Bowie Mill Road

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mathias Whitenight

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Manley Hughes

19a. Informant's Name/Relationship (Type, Print)

Kenneth H. Fraley / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17800 Bowie Mill Road, Derwood, Md. 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Laytonsville Cem.

Date

3/1/07

20c. Location - City or Town, State

Laytonsville, Md.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P. O. Box 5038, Laytonsville, Md. 2088223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

DEMENTIA

Approximate  
Interval Between  
Onset and Death

4 Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

CEREBRAL VASCULAR DISEASE

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)Assisted  
Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis M. Hannon

29c. License number

D 23124

29d. Date signed (Month, Day, Year)

FEBRUARY 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS M. HANNON, M.D. 2901 OLNEY-SANDY SPRING RD., OLNEY, MD. 20832

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08184

1- For State Registrar

Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |   |  |   |  |
|---|---|---|--|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Eddie Gantt</b>                       |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>07</b> , Year <b>2007</b> |   |   |  | 3. Time of Death<br><b>2:50 P M</b>                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>115 Limestone Road</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Hancock</b>                  |   |   |  | 4c. County of Death<br><b>Washington</b>              |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-34-5037</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                        |   | 8. Date of Birth (Month, Day, Year)<br><b>April 21, 1936</b>            |  | 9. Birthplace (State or Foreign Country)<br><b>WV</b> |  |
|   | Usual Residence of Decedent   |   |  |   |   |   |   |  |   |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hancock</b>   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>115 Limestone Road</b>   |   |   |  | 10f. Zip Code<br><b>21750</b>   |   | 10g. Citizen of What Country?<br><b>USA</b> |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   |   | 16b. Kind of Business/Industry<br><b>Agriculture</b>                    |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lester Owen Gantt</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Celly Miller</b>  |   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Nina R. Gantt/Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 Limestone Road Hancock, MD 21750</b>  |   |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stone Bridge Cemetery</b>  |   |   | 20c. Location - City or Town, State<br><b>03/12/07 Hancock, MD</b>      |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Jaffer Lee Davis MD1414</b>   |   |   |  | 22. Name and Address of Facility<br><b>Grove Funeral Home, P.A. Hancock, MD 21750-0368</b>  |   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>MYELODYSPLASTIC SYNDROME</b><br><b>ISCHEMIC CARDIOMYOPATHY</b><br><b>DIABETES MELLITUS</b> |   |   |  |   |   |   |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |   | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MYELODYSPLASTIC SYNDROME</b><br><b>ISCHEMIC CARDIOMYOPATHY</b><br><b>DIABETES MELLITUS</b>   |   |   |  |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>             |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br><b>Brian R Stacey, MD</b>  |   |   |   | 29c. License number<br><b>DE8117/MO</b>  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/8/2007</b>  |   |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>130 WEST HIGH STREET, HANCOCK, MD 21750</b>  |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 15 2007</b>   |   |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21266

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03185

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eliza J. Gerald

2. Date of Death

Month Day Year  
Feb. 27, 2007

3. Time of Death

5:42 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

240-38-2111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 8, 1926

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2100 Wintergreen Ave.

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Cunningham White

18. Mother's Name (First, Middle, Maiden Surname)

Sarah J. Claiborne

19a. Informant's Name/Relationship (Type, Print)

Tilman L. Gerald-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1423 Madison St. N.W. Wash. D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD. Veterans Cem. Mar. 5, 07

Date

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Francis B. Hunt

22. Name and Address of Facility

Hunt Fun. Home 908 Kennedy St. N.W. Wash. DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric McDonald

29c. License number

00064055

29d. Date signed (Month, Day, Year)

2-27-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC McDONALD MD 7503 SURRETT RD. CLINTON, MD 20735

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Barbara D. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08186

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Maynard Warrington Gambrell</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 21, 2007</b>  |  |  |  | 3. Time of Death<br><b>7:45 a M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>16821 Harbour Town Drive</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| 5. Social Security Number<br><b>578-70-5664</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 10, 1950</b> |  | 9. Birthplace (State or Foreign Country)<br><b>District of Columbia</b>  |  |  |  |
| Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Maryland</b>   |  |  |  | 10b. County<br><b>Montgomery</b>   |  |  |  |
| 10c. City, Town or Location<br><b>Silver Spring</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |
| 10e. Street and Number<br><b>16821 Harbour Town Drive</b>   |  |   |  | 10f. Zip Code<br><b>20905</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African-American</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Senior IT Auditor</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Information Technology</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Warrington Gambrell</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Elizabeth McLeod</b>  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Reva J. Gambrell - Spouse</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16821 Harbour Town Drive, Silver Spring, Maryland 20905</b>   |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | Date<br><b>3/1/2007</b>                                      |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, Maryland 20904</b>   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                                     |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred            |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D0064983</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>2/26/07</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kashif Alam Firozvi, M.D., 2101 Medical Park Drive, Suite 200, Silver Spring, Maryland 20902</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08187

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GWENDOLYN VIRGINIA GRIM

2. Date of Death

Feb 26 2007

3. Time of Death

3:05A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Fahney - Keedy Nursing Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-40-2392

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

001-9-1914

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8507 MAPLEVILLE ROAD

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE THOMAS STAUBS

18. Mother's Name (First, Middle, Maiden Surname)

MITTIE RANDOLPH GROVE

19a. Informant's Name/Relationship (Type, Print)

JOYCE G. DEBAUGH, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20605 MILLPOINT ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MTN. VIEW CEMETERY

Date

3/1/2007

20c. Location - City or Town, State

SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BAST FUNERAL HOME

7606 OLD NATIONAL PIKE

BOONSBORO, MARYLAND 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular Disease

Approximate Interval Between Onset and Death

25X

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia

15X

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

052323

29d. Date signed (Month, Day, Year)

02-26-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem, MD 1126 Opal Court, Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08128

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Edwin F. Gnegy

2. Date of Death

Month Day Year  
02 26 2007

3. Time of Death

11:00P M

4a. Facility Name (If not institution, give street and number)

WMHS Frostburg Nursing &amp; Rehab Ctr.

4b. City, Town, or Location of Death

Frostburg, MD

4c. County of Death

Allegany

5. Social Security Number

212-18-1748

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01/27/1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11412 Gnegy Lane

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Walter

Cline

Gnegy

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy

Evans

19a. Informant's Name/Relationship (Type, Print)

Sharon E. Donahoe / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3096 Bedford Valley Road, Bedford, PA 15522

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pleasant Grove Cem.

Date

03/02/2007

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wonsok Shin MD

29c. License number

00055325

29d. Date signed (Month, Day, Year)

Feb 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN MD

48 Turn Terrace

Frostburg, MD 21532

31. Date filed (Month, Day, Year)

Feb 27 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

n&amp;s

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08189

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Wayne Hixon

2. Date of Death  
Month Day Year

March 07, 2007

3. Time of Death

5:40 A. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NMS Health Care of Hagerstown

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

217-12-2297

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

8. Date of Birth (Month, Day, Year)

November 13, 1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

Fulton

10c. City, Town or Location

Warfordsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1731 Lehman Road

10f. Zip Code

17267

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Charles Hixon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Francina Weese

19a. Informant's Name/Relationship (Type, Print)

R. Dale Hixon/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1845 Lehman Road Warfordsburg, PA 17267

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Buck Valley Christian

Date

03/10/07

20c. Location - City or Town, State

Warfordsburg, PA

21. Signature of Funeral Service Licensee

J. Lee Davis MO1414

22. Name and Address of Facility

141 West Main Street  
Grove Funeral Home, P.A. Hancock, MD 21750-0368

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

c. chronic obstructive lung disease

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Yes ☐ No☐ Yes ☐ No

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Lee Davis

29c. License number

D060396

29d. Date signed (Month, Day, Year)

03/07/07

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

FARID MUMSHED

1126 opal ct  
Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

David B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Ky

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03190

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin Clinton Hull

2. Date of Death

February 22 2007

3. Time of Death

3:23P M

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-16-1774

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2517 Barrison Point Rd.

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

machinist

16b. Kind of Business/Industry

machinery

17. Father's Name (First, Middle, Last)

H. Paul Hull

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Engler

19a. Informant's Name/Relationship (Type, Print)

Yette Habicht/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2517 Barrison Point Rd. Baltimore, MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pipe Creek Cemetery

Date

2/26/2007

20c. Location - City or Town, State

nr. Linwood, MD

21. Signature of Funeral Service Licensee

Catherine O'Harley

22. Name and Address of Facility

Hartzler Funeral Home

310 Church St. New Windsor, MD 21776

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain metastases

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Carcinoma of Prostate

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify) *Home*

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Pending investigation8 ☐ Could not be determined9 ☐ Could not be determined10 ☐ Could not be determined11 ☐ Could not be determined12 ☐ Could not be determined13 ☐ Could not be determined14 ☐ Could not be determined15 ☐ Could not be determined16 ☐ Could not be determined17 ☐ Could not be determined18 ☐ Could not be determined19 ☐ Could not be determined20 ☐ Could not be determined21 ☐ Could not be determined22 ☐ Could not be determined23 ☐ Could not be determined24 ☐ Could not be determined25 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MARC L. HOROWITZ

29c. License number

20458217

29d. Date signed (Month, Day, Year)

02/26/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARC L. HOROWITZ 1425 ELLER ST BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

MARC L. HOROWITZ

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08191

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jean Elizabeth Harbold

2. Date of Death  
Month Day Year

February 27, 2007

3. Time of Death

2020 M

4a. Facility Name (If not institution, give street and number)

Carroll Hospital Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

144-22-3249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 9, 1927

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

552 Crossbridge Dr.

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own Home

17. Father's Name (First, Middle, Last)

Carl W. Reamer

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Fidler

19a. Informant's Name/Relationship (Type. Print)

John Harbold

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2344 Sykesville Rd. Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Deer Park Cemetery

Date

3/3/2007

20c. Location - City or Town, State

Smallwood, Maryland

21. Signature of Funeral Service Licensee

John K. Golew III

22. Name and Address of Facility

Pritts Funeral Home and Chapel, PA

412 Washington Rd. Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

pneumonia congestive

ulcerative colitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John K. Golew III MD

29c. License number

231660

29d. Date signed (Month, Day, Year)

03/01/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS K. Golew III 291 STOWER AVENUE WESTMINSTER, MARYLAND 21157

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

John K. Golew III

ORIGINAL

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JEAN ELIZABETH HARBOLD  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08192

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND FRANCIS HAINES

2. Date of Death  
Month Day Year

FEBRUARY 23, 2007

3. Time of Death

1:10 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CROFTON CONVALESCENT CENTER

4b. City, Town, or Location of Death

CROFTON

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

184-22-9261

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

MAY 23, 1930

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

EDGEWATER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

87 STEWART DRIVE #215

10f. Zip Code

21037

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1949-5213. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ELECTRONIC DRAFTSMAN

16b. Kind of Business/Industry

GOVERNMENT  
CONTRACTING

17. Father's Name (First, Middle, Last)

STUART KERMIT HAINES

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE CARVER

19a. Informant's Name/Relationship (Type, Print)

EUGENIA HAINES/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

87 STEWART DR. #215, EDGEWATER, MARYLAND 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HUNT CREMATORY

Date

2/25/2007

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

Robert E. Evans

22. Name and Address of Facility 16000 ANNAPOLIS ROAD, BOWIE, MD

ROBERT E. EVANS FUNERAL HOME

20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

Years

c. Chronic Kidney Disease

Due to (or as a consequence of):

Years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Rakesh Arora MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

2/23/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH AROFA MD, 14300 GALLANT FOX LN, 222 Bowie MD 20715

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Rakesh Arora

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08193

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Marion Hawkins

2. Date of Death

February 25 2007

3. Time of Death

9:12 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

476-09-1076

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

07/02/1920

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Glenn Dale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10012 Dubarry Street

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 44-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Erwin Edward Thomson

18. Mother's Name (First, Middle, Maiden Surname)

Vera Mae Talbert

19a. Informant's Name/Relationship (Type, Print)

Stacey L. Hawkins/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10012 Dubarry Street Glenn Dale, MD 20769

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

Date

02/28/2007

20c. Location - City or Town, State

Waldorf, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Robert E. Evans Funeral Home

16000 Annapolis Road Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cerebrovascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillation

Seizure

Delirium

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Physician2 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 60611

29d. Date signed (Month, Day, Year)

2/26/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL F. ASPA, MD 8118 GOOD LOOK ROAD MD 20769

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

ORIGINAL

Shirley Marion Hawkins  
Baltimore, Maryland 21215-0036

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

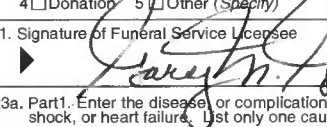
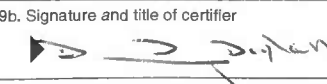

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08194

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>George M. Heller</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>28</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>6:25 a.</b> M   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>515 Apple Grove Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| 5. Social Security Number<br><b>121-22-3953</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>September 14, 1924</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |
| Usual Residence of Decedent   |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>515 Apple Grove Road</b>   |  | 10f. Zip Code<br><b>20904</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-1946</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Statistician</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Census Bureau</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Heller</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tillie Seiff</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sarah Heller - Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8405 Freyman Drive, Chevy Chase, Maryland 20815</b>   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King David Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Falls Church, Virginia</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, Maryland 20904</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular Ischemia (Stroke)</b><br>Due to (or as a consequence of):<br><b>Vasculitis</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>30059884</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/2007</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Damien J. Doyle, M.D., 1801 East Jefferson Street, Rockville, Maryland 20852</b>   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

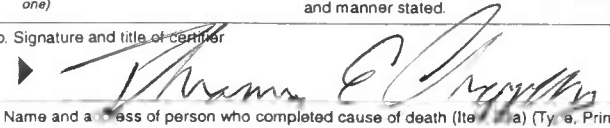

Reg. No.

2007 08195

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>Glen Calvin Hill   |  | 2. Date of Death<br>Month Day Year<br>February 22, 2007   |   | 3. Time of Death<br>10:45 A <sup>M</sup>  |  |
| 4a. Facility Name (If not institution, give street and number)<br>12900 Valley Road, NE  |  | 4b. City, Town, or Location of Death<br>Cumberland  |   | 4c. County of Death<br>Allegany   |  |
| 5. Social Security Number<br>218-24-8653   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>77 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>09/10/1929 | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  |
| Usual Residence of Decedent  |  |   |   |   |  |
| 10a. State<br>MD   | 10b. County<br>Allegany  | 10c. City, Town or Location<br>Cumberland   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br>12900 Valley Road, NE  |  | 10f. Zip Code<br>21502  |   | 10g. Citizen of What Country?<br>USA  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 8   |   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver  |  | 16b. Kind of Business/Industry<br>Manufacturing   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Brethard Hill   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Beulah Ellen Allabaugh   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Helen A. Hill / wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12900 Valley Road, NE., Cumberland, MD 21502   |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunset Memorial Park  |   | 20c. Location - City or Town, State<br>Cumberland, MD   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Bladder Carcinoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |   |  |
| Approximate Interval Between Onset and Death<br>One month  |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D35135   |   | 29d. Date signed (Month, Day, Year)<br>February 23, 2007  |  |
| 30. Name and address of person who completed cause of death (If a) (Type, Print)<br>Thomas E. Chappell, M.D., 912 Seton Drive, Cumberland, MD 21502  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 2007   |  | 32. Registrar's Signature<br>  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08196

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen Louise Hambleton</b>   |  | 2. Date of Death<br>Month <b>03</b> Day <b>01</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>0121 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  | 4c. County of Death<br><b>Cecil</b>  |  |
| 5. Social Security Number<br><b>147-12-7794</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>06-05-1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>NJ</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Elkton</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>170 Vista Dr.</b>  |  | 10f. Zip Code<br><b>21921</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Agent</b>                         |  | 16b. Kind of Business/Industry<br><b>Real Estate Insurance</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence H. Anderson</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Green</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Hambleton/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>170 Vista Dr. Elkton. MD 21921</b>            |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lawncrest Crematory</b>  |  | 20c. Location - City or Town, State<br><b>3-3-07 Linwood, PA</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Edward McIlwain</b>   |  | 22. Name and Address of Facility<br><b>Sharo + Feeley Family Funeral Home<br/>635 Churchmans Rd. Newark DE 19702</b>                              |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. COPD</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>  |  |   |  |  |  |
| Approximate Interval Between Onset and Death  |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Karen S. LeFlore</b>  |  | 29c. License number<br><b>DD062643</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/1/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Karen S. LeFlore Union Hospital 106 Bow St Elkton, MD</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 2 2007</b>  |  | 32. Registrar's Signature<br><b>Kevin B. Spivey</b>   |  |  |  |



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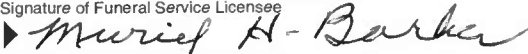
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08197


1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT BRUCE HOSFORD</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 25 2007</b>  |  | 3. Time of Death<br><b>9:05 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>398-16-4241</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs. | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 8 1924</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b> |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Clarksburg</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>24301 Stringtown Road</b>  |  |   |  | 10f. Zip Code<br><b>20871</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>  |  | 16b. Kind of Business/Industry<br><b>Air Condition &amp; Heat</b>                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Raymond L. Hosford</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys L. Loomis</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Irene F. Hosford / Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24301 Stringtown Road, Clarksburg, Md. 20871</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crem.</b>   |  | Date<br><b>2/27/07</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Va.</b>                                      |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Muriel H. Barber Funeral Home<br/>P. O. Box 5038, Laytonsville, Md. 20882</b>   |  |  |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ANOXIC ENCEPHALOPATHY</b>  |  |   |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |
| a. Due to (or as a consequence of):<br><b>ASYSTOLIC CARDIAC ARREST</b>   |  |   |  |  |  |
| b. Due to (or as a consequence of):  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
|  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>0065088</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 26, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOYDIP ROY, M.D. 1500 FOREST GLEN ROAD, SILVER SPRING, MD. 20910</b>  |  |   |  |  |  |

State  
Registrar

FEB 28 2007

31. Registrar's Signature  


ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08198

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Jeffrey P. Hathaway

2. Date of Death

Month Day Year  
February 27, 2007

3. Time of Death

1715 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

993 C Heather Ridge Drive

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

524-92-9572

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

43

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

Feb. 19, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

993 C. Heather Ridge Drive

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Addictions Councilor

16b. Kind of Business/Industry

Rehabilitation

17. Father's Name (First, Middle, Last)

Craig Hathaway

18. Mother's Name (First, Middle, Maiden Surname)

Mary Manning

19a. Informant's Name/Relationship (Type, Print)

Craig Hathaway / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9415 Glade Ave., Walkersville, MD 21793

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Garden

Date

3/3/2007

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Courtney Stauffer

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Sharp Force Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Feb 27, 2007

28b. Time of Injury

FOUND: 1709 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject stabbed and cut self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

993 C Heather Ridge Drive, Frederick, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

Patricia Aronica-Pollak MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 28, 2007

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08199

1- For State Registrar AMEND #31 See #323/1/07, BW, MCO

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie Givens Jackson

2. Date of Death

Month Day Year  
02-27-2007

3. Time of Death

12:30P M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

233 20 9878

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06-28-1918

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

355 Chaptico South

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teachers Aide

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Albert Givens

18. Mother's Name (First, Middle, Maiden Surname)

Sybil Bobbitt

19a. Informant's Name/Relationship (Type, Print)

Shelia A. Gwinn -daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

355 Chapitico South, Laurel, MD 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Blue Ridge Memorial

Date

03-04-2007

20c. Location - City or Town, State

Beckley, WV

21. Signature of Funeral Service Licensee

*W. Off Murray*

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.

5130 Wisconsin Ave., NW Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Hypercholesterolemia

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

24 hours

30 years

50 years

50 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure  
Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*S. Chatrathi MD*

29c. License number

52119

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 302, 8100 Goodluck Rd; Lanham, MD 20106

31. Date filed (Month, Day, Year)

2-27-07

32. Registrar's Signature

MAR 01 2007

*Sam B. Ford*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08200

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JACQUELYNN MARIE JONES

2. Date of Death  
Month Day Year  
FEBRUARY 28, 20073. Time of Death  
11:45 AM

4a. Facility Name (If not institution, give street and number)

RUXTON HEALTH OF DENTON

4b. City, Town, or Location of Death

DENTON

4c. County of Death

CAROLINE

Funeral  
Director

5. Social Security Number

205-32-9884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 25, 1943

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CAROLINE

10c. City, Town or Location

DENTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8158 HARMONY ROAD

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

EARL HAMMOND

18. Mother's Name (First, Middle, Maiden Surname)

ANN CASSIDY

19a. Informant's Name/Relationship (Type, Print)

CHARLES JONES/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8158 HARMONY ROAD, DENTON, MARYLAND 21629

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION

Date

MARCH 1, 2007

20c. Location - City or Town, State

STEVENSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME, P.A.  
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END-STAGE DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
Attending MD

29c. License number

D0053094

29d. Date signed (Month, Day, Year)

3-1-07

30. Name and address of person who completed cause of death (Item 23a.) (Type, Print)

Paul M. Reinbold, MD 321 BLOOMINGDALE AVE FEDERALSBURG, MD 21632

31. Date filed (Month, Day, Year)

MAR 1 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08201

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |   |  |   |  |  |
|--|--|--|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Wills Kuykendall</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>February 23, 2007</b>   |   |  |   | 3. Time of Death<br><b>7:00 aM</b>       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Rehab and Nursing Center</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |   |  |   | 4c. County of Death<br><b>Montgomery</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>526-42-2966</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>November 16, 1933</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Phoenix, Arizona</b>   |  |   |  |  |
|  | Usual Residence of Decedent  |  |   |   |  |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|  | 10e. Street and Number<br><b>1411 Leister Drive</b>  |  |   | 10f. Zip Code<br><b>20904</b>   |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean War</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auditor</b> |  |   | 16b. Kind of Business/Industry<br><b>GAO U.S. Government</b>                                   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Dolph Kuykendall</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Wills</b>  |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cynthia Kuykendall - Daughter</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1411 Leister Drive, Silver Spring, Maryland 20904</b>                                    |   |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico National Cemetery</b>   |   | 20c. Date<br><b>2/28/2007</b>  |   | 20d. Location - City or Town, State<br><b>Triangle, Virginia</b>                               |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, Maryland 20904</b>  |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Poorly Differentiated Prostate Cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |   |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |   |  |   |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   |   |  |   |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |   |  |   |  |   |  |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Obstructive Uropathy</b><br><b>Urinary Tract Infection</b><br><b>Bilateral Pleural Effusions</b>  |  |   |   |  |   |  |   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |   |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |   |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |   |  |   |  |   |  |  |
|  | 28a. Date of Injury (Month, Day Year)  |  |   |   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |  |   |  |  |
|  | 29b. Signature and Title of certifier<br>  |  |   |   |  | 29c. License number<br><b>D0052401</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 23, 2007</b>                             |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas M. Annulis, M.D., 10801 Lockwood Drive, Suite 205, Silver Spring, Maryland 20901</b>   |  |  |   |   |  |   |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  |   |   |  | 32. Registrar's Signature<br>   |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 03202

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David

Loverin

2. Date of Death

Feb. 24, 2007 Year

3. Time of Death

0540 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

001-28-7920

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 22, 1938

9. Birthplace (State or Foreign Country)

NH

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

ODENTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2442 Blue Spring Court Unit 104

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 61-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Project Specialist

16b. Kind of Business/Industry

Gov't Contracts

17. Father's Name (First, Middle, Last)

Ralph

M.

Loverin

18. Mother's Name (First, Middle, Maiden Surname)

Alfreda

Goings

19a. Informant's Name/Relationship (Type. Print)

Janet Loverin Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2442 Blue Spring Court Unit 104 Odenton, MD 21113

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Metro Crematory

Date

Feb. 27, 07

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Janet J. Loverin

22. Name and Address of Facility

Hardesty Funeral Home P.A. 851 Annapolis RD  
Gambrills, MD 21054

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Exacerbation of Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Neil E. Padgett MD

29c. License number

D0033296

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Padgett MD 7711 Quarterfield Road #A Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Karen B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division or Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08203

1- For  
State  
Registrar

|   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Wanda Leeson   |   |  |  | 2. Date of Death<br>Month Day Year<br>February 27, 2007 |  | 3. Time of Death<br>2:18 P.M.                        |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Homewood at Crumland Farms Nursing Ct. |   |  |  | 4b. City, Town, or Location of Death<br>Frederick       |  | 4c. County of Death<br>Frederick                     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>409-48-4172   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>76 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>Sep. 27, 1930 |  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Virginia   |   | 10a. State<br>Maryland   |  | 10b. County<br>Frederick                                |  | 10c. City, Town or Location<br>Jefferson             |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>4303 Horine Court  |   | 10f. Zip Code<br>21755   |  | 10g. Citizen of What Country?<br>United States |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Walter Tate  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Belva Gardner   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Linda Sanbower / Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4303 Horine Court, Jefferson, MD 21755  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fairfax Memorial Park   |  | Date<br>March 3, 2007  |   | 20c. Location - City or Town, State<br>Fairfax, Virginia                             |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Fairfax Memorial Funeral Home<br>9902 Braddock Road, Fairfax, VA 22032  |  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):<br>a. Parkinson's Disease<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br>Years   |  |  |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus type 2<br>Dementia<br>Hypothyroid   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D16428  |   | 29d. Date signed (Month, Day, Year)<br>2/27/07                                       |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Casper Cline, M.D., 300 West 9th Street, Frederick, MD 21701  |  | 31. Date filed (Month, Day, Year)<br>MAR 01 2007  |  | 32. Registrar's Signature<br>  |   |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

08204

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Levine

2. Date of Death  
Month Day Year  
February 15 20073. Time of Death  
6:10 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

5. Social Security Number

034-42-5678

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 19, 1954

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

315 North Charles Street

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1975-7913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
unknownCollege (1-4 or 5+)  
unknown16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled Sign Language Interpreter

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

Frank Levine

18. Mother's Name (First, Middle, Maiden Surname)

Emma Ake

19a. Informant's Name/Relationship (Type, Print)

Roseann Kirby

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 North Charles Street, Baltimore, MD 21201-4325

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Cemetery

Date

03/07/07

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.  
Perryville, Maryland 21903-076623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. MYOCARDIAL INFARCTION  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

UNKNOWN

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RHEUMATOID ARTHRITIS, HYPOTHYROIDISM, POST TRAUMATIC

STRESS DISORDER, OSTEOARTHRITIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Karithanom Isaac M.D.

29c. License number

D40723

29d. Date signed (Month, Day, Year)

2/15/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karithanom Isaac M.D. VA Maryland Health Care System Perry Point, MD 21902

31. Date filed (Month, Day, Year)

MAR 2 2007

32. Registrar's Signature

John B. Speltz

State  
RegistrarName known to physician: LEVINE, PATRICIA  
Baltimore, Maryland 21215-0036permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3-1VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08205

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene Lucas

2. Date of Death

February 28, 2007

3. Time of Death

0800 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12101 Kemp Drive

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

217-28-9908

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 07, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number 12101 Kemp Drive, N.W.

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

maintenance dept.

16b. Kind of Business/Industry

county courthouse

17. Father's Name (First, Middle, Last)

George E. Lucas

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Gibson

19a. Informant's Name/Relationship (Type, Print)

Bonita Lucas wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12101 Kemp Drive, N.W. Frostburg Maryland 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Memorial Park

Date

March 02, 2007 Frostburg Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

DIABETES MELLITUS

Due to (or as a consequence of):

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 years

Due to (or as a consequence of):

HYPERLIPIDEMIA 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at this time, date and place and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Angelina Regno MD

29c. License number

D-0013166

29d. Date signed (Month, Day, Year)

2/28/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGEL H. REGNO MD 48 TANN TERRACE FROSTBURG MD

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

21532

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

124

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08206

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Catherine Lapp

2. Date of Death

February 19, 2007

3. Time of Death

4:14 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lions Center for Rehab &amp; Ext. Care

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

218-12-5228

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02/04/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

LaVale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

540 N. First Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Operator

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Russell Earl

Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Pearl

Miller

19a. Informant's Name/Relationship (Type, Print)

Sherry Laurie / friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Oak Terrace, LaVale, Maryland 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hillcrest Mem. Park

Date

02/22/2007

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Adams Family Funeral Home, P.A.  
404 Decatur Street, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wonsock Shin MD

29c. License number

#D55325

29d. Date signed (Month, Day, Year)

February 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wonsock Shin, MD 48 Tarn Terrace Frostburg, MD 21532

31. Date filed (Month, Day, Year)

FEB 20 2007

32. Registrar's Signature

[Signature]

State  
RegistrarLapp, Lucille C.  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08207

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Constantina

Lafazanios

2. Date of Death

Feb. 24, 2007

3. Time of Death  
2:00p M

4a. Facility Name (If not institution, give street and number)

Collingswood Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

134-30-6908

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/22/1922

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

299 Hurley Avenue

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
4

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Theodore Lafazanios

18. Mother's Name (First, Middle, Maiden Surname)

Stavroula Festas

19a. Informant's Name/Relationship (Type. Print)

Nikolas Mechelis/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4109 Dana Court Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

2/27/2007

20c. Location - City or Town, State

Silver Spring, Md

21. Signature of Funeral Service, Inc.

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE, P.A.  
9241 Columbia Blvd. Silver Spring, Md 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

G. Thaker M.D.

29c. License number

D43430

29d. Date signed (Month, Day, Year)

Feb. 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Thaker MD 11125 Rockville Pike #208 Rockville, Md 20852

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08208

1- For State Registrar

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)

Iva Lee McBee

2. Date of Death

Month Day Year

2

10

07

3. Time of Death

6:15 a.m.

4a. Facility Name (If not institution, give street and number)

Country House Residences

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral Director

5. Social Security Number

235-32-0401

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

5

14

24

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Cumberland Street

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Marvin C. Weber

18. Mother's Name (First, Middle, Maiden Surname)

Flossie Michael Weber

19a. Informant's Name/Relationship (Type, Print)

Deborah Seldomridge

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

335 Hawthorne Rd, Keyser, WV 26726

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Spohrs Cross Roads 2-15-07 Berkeley Springs, WV

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*John A. Anderson*

22. Name and Address of Facility

Hunter-Anderson Funeral Home  
36 S. Green St., Berkeley Springs, WV 25411

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

Sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADVANCE DEMENTIA  
ATRIAL - FIBRILLATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Shiv Khanna*

29c. License number

D445444

29d. Date signed (Month, Day, Year)

2/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Shiv Khanna, 221 E. National Highway, Lavale, Md 21502

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08209

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Paul Russell Mills

2. Date of Death

March 6 2007

3. Time of Death

10:46 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-46-5343

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

8. Date of Birth (Month, Day, Year)

February 15, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Big Pool

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13020 Indian Springs Road

10f. Zip Code

21711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Mills Excavating

17. Father's Name (First, Middle, Last)

Russell Mills

18. Mother's Name (First, Middle, Maiden Surname)

Vergie Reed

19a. Informant's Name/Relationship (Type, Print)

Barbara Revell/Caregiver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13129 Pecktonville Road Big Pool, MD 21711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Shankstown Cemetery

Date

03/09/07

20c. Location - City or Town, State

Big Pool, MD

21. Signature of Funeral Service Licensee

James Lee Davis MD1414

22. Name and Address of Facility

141 West Main Street  
Grove Funeral Home, P.A. Hancock, MD 21750-0368

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of Bronchus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. McMoran MD

29c. License number

041662

29d. Date signed (Month, Day, Year)

3-7-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McMoran 1110 Medical Campus Hagerstown MD

31. Date filed (Month, Day, Year)

MAR 15 2007

32. Registrar's Signature

Karen B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08210

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willard Mahanes

2. Date of Death

February 25 2007

3. Time of Death

3:00A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Westminster Nursing &amp; Rehab. Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

223-38-2656

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 5, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 Hillside Court

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1944-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

parts dept. clerk/ salesman

16b. Kind of Business/Industry

hardware store/ lawn &  
garden equipment

17. Father's Name (First, Middle, Last)

Samuel Timothy Mahanes

18. Mother's Name (First, Middle, Maiden Surname)

Lilith Broadhead

19a. Informant's Name/Relationship (Type, Print)

Mabel L. Mahanes/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 823 Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pipe Creek Cemetery

Date

3/1/2007

20c. Location - City or Town, State

nr. Linwood, MD

21. Signature of Funeral Service Licensee

Catherine O. Harbler

22. Name and Address of Facility

Hartzler Funeral Home  
310 Church St. New Windsor, MD 2177623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

b. Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 wk

25 yr

Sequentially list conditions  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John W. Middleton MD

29c. License number

D 25443

29d. Date signed (Month, Day, Year)

2/26/2007

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

John W. Middleton MD 688 Poole Rd, Westminster, MD 21157

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

K. K. K.

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2064.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08211

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BEVERLY MELVIN

2. Date of Death

FEBRUARY 26, 2007

3. Time of Death

2:48A.<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-76-3974

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth (Month, Day, Year)

MARCH 26, 1956

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6103 L ST.,

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME CARE

17. Father's Name (First, Middle, Last)

RAYMOND WASHINGTON

18. Mother's Name (First, Middle, Maiden Surname)

ELEANOR GAINES

19a. Informant's Name/Relationship (Type, Print)

BERNON WASHINGTON/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9703 FOX RUN DR. CLINTON MD. 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

3/5/07

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

Sharon Johnson Shelby

22. Name and Address of Facility

CAPITOL MORTUARY  
1425 MARYLAND AVE., N.E. WASH., D.C. 20002

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Circulosis of Livers

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Congestive

Hypertension

Severe metabolic acidosis

Aspiration pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. M. D.

29c. License number

D0064801

29d. Date signed (Month, Day, Year)

2/26/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhann Patel 7503 SARRANTS RD. CLINTON, MD. 20735

State Registrar

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

B. M. D.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08212

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERIC Mc Koy

2. Date of Death

Month

Day

Year

3. Time of Death

2 24 2007 0915 M

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

579-96-4669

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

8. Date of Birth (Month, Day, Year)

MAY 22, 1970

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4281 6th St., S.E. #202

10f. Zip Code

20032

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUS DRIVER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

JOHN LOVE

18. Mother's Name (First, Middle, Maiden Surname)

VENTSENE McKOY

19a. Informant's Name/Relationship (Type, Print)

VENTSENE LOVE/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4281 6th St., S.E. #202 WASHINGTON, D.C. 20032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

3-3-07

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

Sharon Johnson-Salley

22. Name and Address of Facility

CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., D.C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GLYCEMIC DISTURBANCE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ COA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ethel Weid MD

29c. License number

A44176435W17470

29d. Date signed (Month, Day, Year)

2/24/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ETHEL WEID 4526 KESWICK RD. BALTIMORE, MD 21210

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08213

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM A. MITCHELL

2. Date of Death

02-26-2007

3. Time of Death

2254P M

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

579-34-3725

6. Sex

188 M 20 F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-25-1929

9. Birthplace (State or Foreign Country)

Alex., Va.

Usual Residence of Decedent

10a. State  
Maryland Prince George's

10b. County

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

13 Yes 20 No

10e. Street and Number

6004 Mentana Street

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Overhead Lineman

16b. Kind of Business/Industry

Pepco

17. Father's Name (First, Middle, Last)

Harry Blake

18. Mother's Name (First, Middle, Maiden Surname)

Grace Lloyd

19a. Informant's Name/Relationship (Type, Print)

William S. Mitchell/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3385 Ferry Landing Road Dunkirk, Maryland 20754

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

03-03-2007

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of lung  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
10 Yes 20 No  
90 Unknown23c. If yes, outcome of pregnancy  
10 Live birth 20 Fetal death  
40 Pregnant at time of death  
90 Unknown30 Ectopic pregnancy  
50 Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

myocardial infarct  
Hypertension  
chronic obstructive lung disease

23e. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?  
10 Yes 20 No24b. Were autopsy findings available prior to completion of cause of death?  
10 Yes 20 No25. Was case referred to medical examiner?  
(Check only one)

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

20 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D13339

29d. Date signed (Month, Day, Year)

02-28-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsunie Chan-Chien, MD 8824 Cunningham Drive Greenbelt, Md. 20740

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08214

1- For State Registrar

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

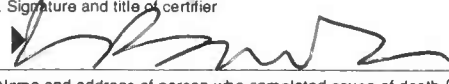
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ERNEST McDONALD</b>   |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 26, 2007</b>   |  | 3. Time of Death<br><b>8:45 a M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>FORT WASHINGTON HEALTH &amp; REHAB.</b>   |  | 4b. City, Town, or Location of Death<br><b>FORT WASHINGTON</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| 5. Social Security Number<br><b>127-07-4853</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>07-13-1918</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>NEW JERSEY</b>  |  |  |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PRINCE GEORGES</b>   |  | 10c. City, Town or Location<br><b>CLINTON</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |
| 10e. Street and Number<br><b>8600 MIKE SHAPIRO DR., #1104</b>  |  | 10f. Zip Code<br><b>20735</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1940-45</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAIL CARRIER</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. POST OFFICE</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ERNEST A. McDONALD</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LUELLA VAUGHN</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARIE R. CURTIS - SISTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20743 7006 VALLEY PARK RD., CAPITOL HEIGHTS, MD</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RIVERDALE CREM.</b>   |  | 20c. Location - City or Town, State<br><b>03-05-2007 RIVERDALE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Urinary Bladder Cancer</b><br>Due to (or as a consequence of):<br><b>Metastatic Lung &amp; Pleura</b><br>Due to (or as a consequence of):<br><b>2week</b><br><b>2week</b> |  | Approximate Interval Between Onset and Death<br><b>2week</b><br><b>2week</b>   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown                                 |  | 23d. Date of delivery<br>Month Day Year  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                    |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D-24535</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02, 28, 07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. LAXMI N. BAWA - 7700 OLD BRANCH AVENUE, SUITE #101 CLINTON, MARYLAND 20735</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08215

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene D. Morton, Jr.

2. Date of Death

Month Day Year  
February 24, 2007

3. Time of Death

5:20 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

452-14-9272

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

November 5, 1917

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15310 Pine Orchard Drive, #1A

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Civil Engineering

17. Father's Name (First, Middle, Last)

Eugene D. Morton

18. Mother's Name (First, Middle, Maiden Surname)

Rosa M. Chatham

19a. Informant's Name/Relationship (Type, Print)

Barry E. Morton - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9126 Belvedere Drive, Frederick, Maryland 21704

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Parklawn Memorial Park &  
Menorah Gardens

Date

3/1/2007

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.  
11800 New Hampshire Avenue, Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Arrhythmia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
30 MINUTESSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Ruptured Abdominal Aneurysm  
Due to (or as a consequence of):

One Hour

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DCA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

10058770

29d. Date signed (Month, Day, Year)

February 24, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy Graf, M.D. 18101 Prince Philip Drive, Olney, MD 20832

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Elliot Mitchell

2. Date of Death

February 23, 2007

3. Time of Death  
8:15 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Collingswood Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

030-09-4516

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

01/10/1918

9. Birthplace (State or Foreign Country)

CT

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6104 Robinwood Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Scientist / Engineer

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

Julius Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Ganzburg

19a. Informant's Name/Relationship (Type, Print)

Jason Mitchell - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Climbing Rose Court Rockville MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial Gardens

Date

2/27/07

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

FAILURE TO THRIVE

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CARDIOMYOPATHY

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

00062435

29d. Date signed (Month, Day, Year)

2/27/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYED ELSAYYAD, MD 9715 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08217

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BESSIE MARCO

2. Date of Death

FEBRUARY 24, 2007 5:00 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

115-38-9041

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/6/11

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6111 Montrose Rd.

10f. Zip Code

20852

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Meyer Letven

18. Mother's Name (First, Middle, Maiden Surname)

Fanny Barr

19a. Informant's Name/Relationship (Type, Print)

Leonard J. Marco/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6724 Heatherford Ct. Rockville, Md. 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Beth David Cemetery 02/28/07

Date

20c. Location - City or Town, State

Elmont, NY

21. Signature of Funeral Service Licensee

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville, Md. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIAL HYPERTENSION

Due to (or as a consequence of):

b. SENILE DEMENTIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Barker Lebony MD.

29c. License number

D 35436

29d. Date signed (Month, Day, Year)

FEBRUARY 24, 2007

30. Name and address of person who completed cause of (Item 23a) (Type, Print)

BESSIE MARCO MARCO 6121 MONTROSE ROAD, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

MAR 01 2007

Registrar's Signature

Barker Lebony

Baltimore, Maryland 21215-0036

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar


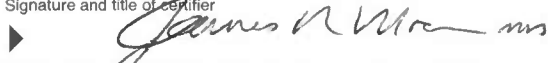

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08218

|   |  |  |   |  |   |   |   |   |
|---|--|--|---|--|---|---|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN FRANCIS MCKENZIE</b>   |  |   | 2. Date of Death<br>Month <b>02</b> Day <b>25</b> Year <b>07</b>   |   | 3. Time of Death<br><b>10:25A. M</b>  |   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WMHS BRADDOCK CAMPUS</b>  |  |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |   | 4c. County of Death<br><b>ALLEGANY</b>  |   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-50-0132</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>February 22, 1947</b>         |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>  |   | 10c. City, Town or Location<br><b>Frostburg</b>                         |   |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>10031 Piney Mountain Road, S.W.</b>  |  | 10f. Zip Code<br><b>21532-</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |   |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>attendant</b>   |  | 16b. Kind of Business/Industry<br><b>gas station</b>  |   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Frederick McKenzie</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Bowers</b>  |   |   |   |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary McKenzie wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10031 Piney Mountain Road Frostburg Maryland 21532</b> |   |   |   |   |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Saint Michael's Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Frostburg Maryland</b>  |   | 20d. Date<br><b>February 28, 2007</b>                                   |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>  |   |   |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |   | Approximate Interval Between Onset and Death<br><b>ONE HOUR</b> |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No<br><b>9</b> Unknown  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown |  |   | 23d. Date of delivery<br>Month Day Year   |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |   |   |   |   |
|   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)            |  |   |   |   |   |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |   |
|   | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |   |   |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D33417 (MARYLAND)</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 25, 2007</b>   |   |   |   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES R. MOLEN, MD 1065 NATIONAL HIGHWAY LAUREL, MARYLAND 21502</b>   |  |   |  |   |   |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 26 2007</b>  |  | 32. Registrar's Signature<br>  |  |   |   |   |   |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08219

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Ann McPeak

2. Date of Death

Month Day Year  
FEBRUARY 27 2007

3. Time of Death

22 42 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

500-40-5925

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 25, 1937

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

428 Harford Street

10f. Zip Code

21903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Twelve Years

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dietetics Department

16b. Kind of Business/Industry

V.A. Medical Center

Perry Point, Maryland

17. Father's Name (First, Middle, Last)

Roscoe Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Illa Wiggins

19a. Informant's Name/Relationship (Type, Print)

Raymond J. McPeak, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

428 Harford Street, Perryville, Maryland 21903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brookview Cemetery

Date

03/07/07

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

Thomas A. Patterson

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.  
Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY DISEASE OF UNKNOWN ETIOLOGY  
Due to (or as a consequence of):

3 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adam Posner MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

FEBRUARY 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADAM POSSNER MD, 4940 EASTERN AVENUE BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

MAR 2 2007

32. Registrar's Signature

Barbara A. Spiller

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

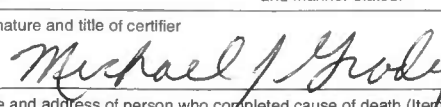
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08220

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John W. Margosian</b>  |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 23, 2007</b>   |  | 3. Time of Death<br><b>7:50 A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9709 Kentsdale Dr.</b>   |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>117-12-9605</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>June 13, 1916</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Potomac</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>9709 Kentsdale Dr.</b>  |  | 10f. Zip Code<br><b>20854</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electronic Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>Litton Industries</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Vartan Margosian</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Estella Bakalian</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alice E. Margosian / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9709 Kentsdale Dr. Potomac, Maryland 20854</b>  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Falls Church, Va.</b>   |  |
| 20d. Date<br><b>3-5-2007</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Ave. N.W. Washington D.C. 20016</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Atherosclerotic Vascular Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |  | years   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown   |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Hyperlipidemia</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  |
| 29c. License number<br><b>MD15901</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Feb. 26, 2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Grady, MD 4201 Cathedral Ave. N.W. # 114</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | Registrar's Signature<br>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend # 17&amp;18 per FH/PHYS 03-05-2007 of Death

Reg. No. 2007 08221

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Glenn Alexander Maktos

2. Date of Death  
Month Day Year  
February 27, 20073. Time of Death  
1:02 P M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-52-7696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 25, 1949

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Monrovia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

721 Blueberry Drive

10f. Zip Code

21770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engraver

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

P. D. Maktos Protogoras Dimitri Maktos

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie A. Skelly Unknown

19a. Informant's Name/Relationship (Type, Print)

Scott Maktos / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 2614  
Kill Devil Hills, North Carolina 27948

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematorium

Date

3/1/07

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

▶ Heather M. Hoff

22. Name and Address of Facility

Molesworth-Williams P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Embolus

a. Due to (or as a consequence of):

Deep Vein Thrombosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death  
1 Day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ James Michael Anchors, M.D.

29c. License number

D29730

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Michael Anchors, M.D. 16220 Frederick Road, Suite 210 Gaithersburg, MD 20877

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

James H. Smith

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2007 02222

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nadia Naydich

2. Date of Death  
Month Day Year

February 23, 2007

3. Time of Death  
p M

8:30 p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6204 Lone Oak Drive

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

213-31-3051

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 24 Hrs.  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)

October 30, 1922

9. Birthplace (State or Foreign  
Country)

Ukraine

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

6204 Lone Oak Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Caucasian15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Entomologist

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Leonid Naydich

18. Mother's Name (First, Middle, Maiden Surname)

Esther Henven

19a. Informant's Name/Relationship (Type, Print)

Yelena Nusinovich / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6204 Lone Oak Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

2/25/2007

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Muelin T. Klebert

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Avenue, Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cancer of the Pancreas

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
3 YearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nelson Kalil, M.D.

29c. License number

D51616

29d. Date signed (Month, Day, Year)

2/25/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nelson Kalil, M.D.

5454 Wisconsin Avenue #130, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Nelson Kalil

Baltimore, Maryland 21215-0036

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/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08223

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Elizabeth Nolan

2. Date of Death

February 28 2007 6:10 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

5. Social Security Number

031-14-5876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth

October 19, 1926

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1306 Leicester Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

County Schools

17. Father's Name (First, Middle, Last)

John Roche

18. Mother's Name (First, Middle, Maiden Surname)

Mary Roche

19a. Informant's Name/Relationship (Type, Print)

Mary Boley/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1306 Leicester Drive, La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 3/2/2007

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

David C. Echols

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

211 St. Mary's Ave. La Plata, MD 20646

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

days

a. Due to (or as a consequence of):

Dementia

years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression, Malnutrition,  
chronic kidney disease, Hypertension,  
Diabetes mellitus, Hypothyroidism.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Sindhiani

29c. License number

D- 61614

29d. Date signed (Month, Day, Year)

February 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVINDER K. SINDHWANI 11350 PEMBROOK SQ. SUITE 304 WALDORF, MD 20603

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

R. Sindhiani

State Registrar

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08224

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frances Kelemen Palenscar

2. Date of Death

February 26, 2007

3. Time of Death

12:47 A M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

101-12-6871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 2, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 Americana Drive, Apt. 22

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Kelemen

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Kravits

19a. Informant's Name/Relationship (Type, Print)

Alexander J. Palenscar, Jr./spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

700 Americana Drive, Apt. 22 Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington Nat. Cemetery

Date

3/15/2007

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

J Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Aortic Stenosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Peripheral  
Arterial Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J Todd E. Liller

29c. License number

D61829

29d. Date signed (Month, Day, Year)

2/26/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reynaldo Lee-Clace II, M.D.

2001 Medical Parkway  
Annapolis, MD 21401

31. Date filed (Month, Day, Year)

FEB 28 2007

Registrar's Signature

J Todd E. Liller

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08225

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

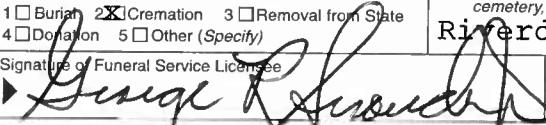
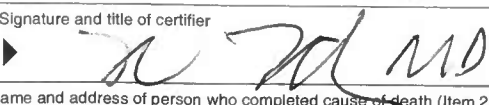

|  |  |   |  |   |                                |   |   |
|--|--|---|--|---|--------------------------------|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>REGINALD LEE PRATT, SR.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 14, 2007</b>  |                                | 3. Time of Death<br><b>1940 p.m.</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |                                | 4c. County of Death<br><b>PRINCE GEORGE'S</b>   |   |
| 5. Social Security Number<br><b>223-54-0372</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 11, 1941</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
| Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                |   |   |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Fort Washington</b>   |                                |   |   |
| 10e. Street and Number<br><b>1624 Taylor Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20744</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>   |                                | 16b. Kind of Business/Industry<br><b>Construction</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>William A. Pratt</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Holmes</b>   |                                |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Pratt / Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6005 67th Ave. Riverdale, Md. 20737</b>   |                                |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Date<br><b>2-22-07</b>  |                                | 20c. Location - City or Town, State<br><b>Beltsville, Md.</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Theron Johnson Salley</i>  |  |   |  | 22. Name and Address of Facility<br><b>Capitol Mortuary, Inc.<br/>1425 Maryland Ave., N.E. Washington, DC 20002</b>   |                                |   |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. FATAL CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death  |                                |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown    |                                | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |  |   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |                                |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and Title of certifier<br><i>[Signature]</i>   |                                |   |   |
| 29c. License number<br><b>D58957</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>2-16-07</b>   |                                |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GARY LITTLE, MD 3001 HOSPITAL DR CHEVERLY, MD 20786</b>   |  |   |  |   |                                |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |   |   |

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08226

1- For  
State  
Registrar

|   |  |  |  |  |   |   |  |  |   |  |
|---|--|--|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE DELMORE PRATT</b>  |  |  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 21, 2007</b>                       |  | 3. Time of Death<br><b>8:20 PM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5413 Bishops Head Court</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   |  | 4c. County of Death<br><b>HOWARD</b>   |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-12-4152</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 21, 1922</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |  |  |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>5413 Bishops Head Court</b>   |  |  |  | 10f. Zip Code<br><b>21044</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>44-45</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>11th</b> Elementary/Secondary (0-12) <b>College (1-4or 5+)</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Worker</b>  |   |  | 16b. Kind of Business/Industry<br><b>City of Rockville</b>                                     |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Russell Nugent</b>   |  |  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Hackett</b>        |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Claggett (Daughter)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5413 Bishops Head C., Columbia, MD 21044</b>  |   |  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Riverdale Park Cre.</b>   |  | Date<br><b>2/27/07</b>  |   | 20c. Location - City or Town, State<br><b>Riverdale, MD</b>                      |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>246 N. Washington St, Rockville, MD 20850</b>  |  |   |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Prostate Cancer</b>  |  |  |  |   |   |  |  |   |  |
|   | 23b. Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |  |
|   | 23c. Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |  |
|   | 23d. Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b>   |  |  |  |   |   |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |   |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |   |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |   |  |  |   |  |
| State Registrar                               | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D56797</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/27/07</b>                            |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lautha Tadikonda, M.D. 13952 Baltimore Ave., Laurel, MD 20707</b>   |  |  |  |   |   |  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>  |  |  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 08227

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)  
**Dolores L. Quander**

2. Date of Death  
Month **March** Day **5** Year **2007**

3. Time of Death  
**1715 hrs**

Funeral  
Director

4a. Facility Name (If not institution, give street and number)  
**Sinai Hospital**

4b. City, Town, or Location of Death  
**Baltimore**

4c. County of Death

5. Social Security Number  
**577-46-0506**

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
**79** Yrs

If Under 1 Year  
Months Days

If Under 24Hrs.  
Hours Min.

8. Date of Birth (MM/DD/YYYY)  
**Oct. 3, 1927**

9. Birthplace (State or Foreign Country)  
**Washington**

Usual Residence of Decedent

10a. State  
**DC**

10b. County  
**N/A**

10c. City, Town or Location  
**Washington**

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number  
**206 17th St. N.E.**

10f. Zip Code  
**20002**

10g. Citizen of What Country?  
**U.S.A.**

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.  
Specify: **Black**

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
**2**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
**Receptionist**

16b. Kind of Business/Industry  
**BCBS**

17. Father's Name (First, Middle, Last)  
**Sedwick D. Lander**

18. Mother's Name (First, Middle, Maiden Surname)  
**Dorothy M. Kit**

19a. Informant's Name/Relationship (Type, Print)  
**Bruce S. Quander / Son**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**206 17th St. N.E. Washington, D.C. 20002**

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)  
**Harmony Cemetery**

20c. Location - City or Town, State  
**March 13, 2007 Landover, MD**

21. Signature of Funeral Service Licensee  
*Thomas B. Cyburn*

22. Name and Address of Facility  
**McGuire Funeral Service**  
**7400 Georgia Ave., N.W. Washington, D.C. 20012**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. **Fat emboli complicating hypertensive atherosclerotic cardiovascular disease**

Due to (or as a consequence of): **disease**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED ☐ AMENDED  
**#23a, 27, per ME, g865, 3/23/07 TT**

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other.

27. Manner of Death  
1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
*Dolores L. Quander*

29c. License number  
**O.C.M.E.**

29d. Date signed (Month, Day, Year)  
**March 6, 2007**

30. Name and address of person who completed cause of death (Item 23a)  
**Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201**

31. Date filed (Month, Day, Year)  
**MAR 12 2007**

32. Registrar's Signature  
*[Signature]*

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08228

1- For  
State  
Registrar

|   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|---|---|------------------------------------|--|--|--|---|--|---|--|--|--|------------------------------------|---|--|-----------------|-------------------------------------|--|-------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert William Rohr</b>  |                                    |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>27</b> Year <b>2007</b>   |   |  |   | 3. Time of Death<br><b>7:39 a M</b>  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7439 First League</b>  |                                    |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |   |  |   | 4c. County of Death<br><b>Howard</b>   |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-32-1039</b>   |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 22, 1928</b>        |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | Usual Residence of Decedent   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |                                    | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 10e. Street and Number<br><b>14512 Fiske Drive</b>  |                                    |  |  | 10f. Zip Code<br><b>20906</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                        |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean Conflict</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>  |  |  | 16b. Kind of Business/Industry<br><b>Moving &amp; Storage Company</b> |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Herman Wadsworth Longfellow Rohr</b>  |                                    |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosalie Elizabeth Clark</b>  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Terri Hopkins Rohr/ Wife</b>   |                                    |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14512 Fiske Drive, Silver Spring, MD 20906</b>   |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | Date<br><b>Feb. 28</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | 21. Signature of Funeral Service Licensee<br>   |                                    |  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W., Silver Spring, MD 20901</b>   |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | Immediate Cause (Final disease or condition resulting in death)   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
|   | <table border="0"> <tr> <td rowspan="4">           Sequentially list conditions, if any, leading to final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Cerebrovascular Accident</b></td> <td>Approximate Interval Between Onset and Death<br/><b>48 Hours</b></td> </tr> <tr> <td>Due to (or as a consequence of):<br/><b>Diabetes Mellitus</b></td> <td><b>17 years</b></td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> </table> |                                    |  |  |  |   |  |   |  |  | Sequentially list conditions, if any, leading to final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Cerebrovascular Accident</b> | Approximate Interval Between Onset and Death<br><b>48 Hours</b> | Due to (or as a consequence of):<br><b>Diabetes Mellitus</b> | <b>17 years</b> | b. Due to (or as a consequence of): |  | c. Due to (or as a consequence of): |  |
|   | Sequentially list conditions, if any, leading to final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>Cerebrovascular Accident</b> | Approximate Interval Between Onset and Death<br><b>48 Hours</b>  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| Due to (or as a consequence of):<br><b>Diabetes Mellitus</b>  |   | <b>17 years</b>                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| b. Due to (or as a consequence of):   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| c. Due to (or as a consequence of):   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 23d. Date of delivery<br>Month Day Year   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperlipidemia, Hypertension</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Daughter's</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28a. Date of Injury (Month, Day Year)   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28b. Time of Injury<br><b>M</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28d. Describe how injury occurred<br><b>Residence</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 29b. Signature and title of certifier<br><b>Barry K. Lance, M.D.</b>  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 29c. License number<br><b>D27733</b>  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 29d. Date signed (Month, Day, Year)<br><b>02/28/07</b>  |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barry K. Lance, M.D. 14201 Laurel Park Drive, #214, Laurel, MD 20707</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |
| 32. Registrar's Signature<br>   |   |                                    |  |  |  |   |  |   |  |  |  |                                    |   |  |                 |                                     |  |                                     |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08229

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Cook

Richardson

2. Date of Death  
Month Day Year

Feb. 26, 2007

3. Time of Death  
Month Day Year

3:47 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3160 Gracefield Rd-Riderwood Village

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579 26 8690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

08-26-1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3160 Gracefield Rd.

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Engraving

17. Father's Name (First, Middle, Last)

Raymond Fraise Cook

18. Mother's Name (First, Middle, Maiden Surname)

Norma Amelia Anderson

19a. Informant's Name/Relationship (Type, Print)

Margaret Machado-Poisson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

157 Inverness Rd. Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cem.

Date

03-05-2007

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

W. R. Murray

22. Name and Address of Facility

Joseph Gawler's Sons Inc.  
5130 Wisconsin Ave. NW Washington, DC 20016

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arterial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. R. Murray

29c. License number

D34590

29d. Date signed (Month, Day, Year)

02-27-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Rd. Silver Spring, MD 20904/Roy Fried

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

W. R. Murray

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08230

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Helen RICHARDSON

2. Date of Death

March

Day

2007

3. Time of Death

10:36 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-28-3065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

Sept. 8 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Washington10c. City, Town or Location  
Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

815 Maryland Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

Charles Henry Mullenix

18. Mother's Name (First, Middle, Maiden Surname)

Esta Mae Vinson

19a. Informant's Name/Relationship (Type, Print)

Elenora Murray - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46 S. Colonial Drive, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

3/6/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Munnix

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL MULTILOBAR PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION; ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vander J. Bradford

29c. License number

D38892

29d. Date signed (Month, Day, Year)

3/2/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAMELA FOX BRADFORD, MD SUITE 130 1110 MEDICAL CAMAR RD MD 21742

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Karen B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08231

1- For  
State  
Registrar

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Gwendolyn Ann Robey                  |   |   | 2. Date of Death<br>Month Day Year<br>February 28, 2007  |  | 3. Time of Death<br>11:25A M   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Waldorf Center |   |   | 4b. City, Town, or Location of Death<br>Waldorf  |  | 4c. County of Death<br>Charles   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-74-9819   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>71 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>August 16, 1935 |  | 9. Birthplace (State or Foreign Country)<br>WashingtonDC |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Charles  |   | 10c. City, Town or Location<br>Waldorf   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br>12303 Burning Oak Court  |  |   | 10f. Zip Code<br>20601  |  | 10g. Citizen of What Country?<br>USA                   |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Disabled |  | 16b. Kind of Business/Industry                         |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Willard Robey, Sr.   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie L. Messick  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joanne Kellam/Sister   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9811 N.C. Highway 58 South, Elm City, NC 27822  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Joseph's Cemetery   |   | Date<br>3/2/2007   |  | 20c. Location - City or Town, State<br>Pomfret, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br>M00817  |  | 22. Name and Address of Facility<br>AREHART-ECHOLS FUNERAL HOME, P.A.<br>211 St. Mary's Ave. La Plata, MD 20646   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>atherosclerotic cardiovascular disease</i><br>Due to (or as a consequence of):<br>b. <i>hypertension</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  | Approximate Interval Between Onset and Death             |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |  |   |   | 29c. License number<br>D 22574 MD  |  | 29d. Date signed (Month, Day, Year)<br>March 1, 2007   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert Pace M.D. 12070 Old Line Ctr #302 Waldorf, MD 20604   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 02 2007   |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



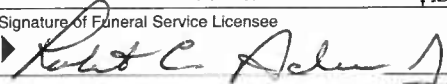
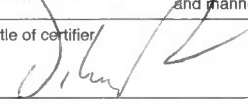

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08232

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>HILDA MELVINA ROOT</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 17, 2007</b>  |  | 3. Time of Death<br>M<br><b>1815</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Memorial</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |   |
| 5. Social Security Number<br><b>220-10-9398</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>03/09/1920</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
| Usual Residence of Decedent   |  |   |  |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>11900 Knob Road</b>  |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>James R. Smith</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura A. Crites</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James W. Root / son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10404 M.V. Smith Road, Flintstone, MD 21530</b>   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Vet. Cem @ Rocky Gap</b>  |  | 20c. Location - City or Town, State<br><b>02/21/2007 Flintstone, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Adams Family Funeral Home, P.A.<br/>404 Decatur Street, Cumberland, MD 21502</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Urosepsis</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of): |  |   |  |  | Approximate Interval Between Onset and Death  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>  |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
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| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M                                 | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D36766</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 18, 2007</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Vik Poonai, 924 Seton Drive, Cumberland, MD 21502</b>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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pe

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillie Jane Ray

2. Date of Death  
Month Day Year

February, 28 2007

3. Time of Death

1:25 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Beverly Health Care

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

213-16-1002

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

March 4, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

322 Braddock Ave.

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert W. Crum

18. Mother's Name (First, Middle, Maiden Surname)

Eva Burke

19a. Informant's Name/Relationship (Type, Print)

Donna Dorsey / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

329 Braddock Ave., Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kemptown Cemetery

Date

3/5/2007

20c. Location - City or Town, State

Kemptown, Maryland

21. Signature of Funeral Service Licensee

Donna Dorsey

22. Name and Address of Facility

1621 Opossumtown Pike, Frederick, MD 21702

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Alzheimer's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Month

year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Speed Zaidi MD

29c. License number

D43091

29d. Date signed (Month, Day, Year)

3-2-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Speed Zaidi MD

801 Toll House Ave, Frederick

31. Date filed (Month, Day, Year)

MAR 9 2 2007

32. Registrar's Signature

Heaven B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08234

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eunice Kathleen Rhoderick

2. Date of Death

Month Day Year  
February 26, 2007

3. Time of Death

5:20 A M

4a. Facility Name (If not institution, give street and number)

Carroll Hospital Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-22-9966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 3, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4101 Old National Pike

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William Lloyd Emswiler

18. Mother's Name (First, Middle, Maiden Surname)

Martha May Brown

19a. Informant's Name/Relationship (Type, Print)

Karen Johnson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1089 Lost River Ridge Circle  
Wardenville, West Virginia 26851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Resthaven  
Memorial Gardens

Date

3/2/07

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Heather M. Hoff

22. Name and Address of Facility

Molesworth-Williams P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 2087223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Atherosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
minutes

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Accident, Diabetes Mellitus,

Hypertension and Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Melvin Joel Kordon MD

29c. License number

D06588

29d. Date signed (Month, Day, Year)

3/1/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melvin J Kordon MD 4501 Old Annapolis Rd Ellicott City MD

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08235

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Irving Sherbert

2. Date of Death

FEB 26 Day 2007 Year

3. Time of Death

7:30 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

957 Mt Holly Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

220-36-6935

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 27 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

957 Mt Holly Drive

10f. Zip Code

21409

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1959-1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Parts Department

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Willard Sherbert

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Bowen

19a. Informant's Name/Relationship (Type, Print)

Mary Jo Sherbert Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

957 Mt Holly Drive Annapolis, MD 21409

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Feb 28 2007

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PANCREATIC CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16364

29d. Date signed (Month/Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER GRADE MD 300 ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08236

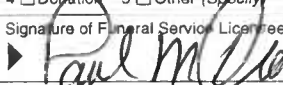

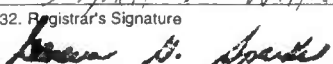
1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                             |  |   |  |   |  |  |  |  |  |
|-----------------------------|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner |  | 1. Decedent's Name (First, Middle, Last)<br><b>KATHERINE ELIZABETH STINE</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 23 2007</b>  |  | 3. Time of Death<br><b>1:46 P M</b>  |  |
| Funeral Director            |  | 4a. Facility Name (If not institution, give street and number)<br><b>16923 VIRGINIA AVENUE</b>  |  | 4b. City, Town, or Location of Death<br><b>WILLIAMSPORT</b>   |  | 4c. County of Death<br><b>WASHINGTON</b>   |  |  |  |
|                             |  | 5. Social Security Number<br><b>217-56-1811</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 20, 1921</b>  |  |
|                             |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WASHINGTON</b>   |  | 10c. City, Town or Location<br><b>WILLIAMSPORT</b>   |  |
|                             |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>16923 VIRGINIA AVENUE</b>  |  | 10f. Zip Code<br><b>21795</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|                             |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|                             |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
|                             |  | 17. Father's Name (First, Middle, Last)<br><b>ROY WILLIAM HIMES</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SADIE MAE HAWKER</b>   |  |  |  |
|                             |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BRIAN D. STINE/GRANDSON</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16923 VIRGINIA AVENUE, WILLIAMSPORT, MARYLAND 21795</b>   |  |  |  |  |  |
|                             |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTHAVEN MEM. GARDENS</b>   |  | 20c. Date<br><b>2/28/2007</b>  |  | 20d. Location - City or Town, State<br><b>FREDERICK, MARYLAND</b>  |  |
|                             |  | 21. Signature of Funeral Service Licensee<br> <b>Paul M. Dean</b>  |  | 22. Name and Address of Facility<br><b>BAST FUNERAL HOME</b>  |  | 22b. Address<br><b>7606 Old National Pike Boonsboro, Maryland 21713</b>  |  |  |  |
|                             |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|                             |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|                             |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b><br><b>diabetes mellitus</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                             |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|                             |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
|                             |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|                             |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|                             |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
|                             |  | 29b. Signature and title of certifier<br> <b>Matthew Gibson MD</b>   |  | 29c. License number<br><b>D0063593</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/27/07</b>  |  |  |  |
|                             |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Matthew Gibson MD 3 Byrd St Williamsport MD 21795</b>  |  |   |  |  |  |  |  |
|                             |  | 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2007 08237

Reg. No.

Physician  
/Medical  
Examiner

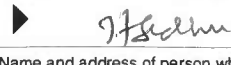
Funeral  
Director

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |   |  |  |                                |   |  |   |  |
|---|--|---|--|--|--------------------------------|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Louise Snyder</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>17</b> Year <b>2007</b>   |                                |   |  | 3. Time of Death<br><b>13:50</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Frostburg Village Nursing Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Frostburg</b>   |                                |   |  | 4c. County of Death<br><b>Allegany</b>  |  |
| 5. Social Security Number<br><b>176-16-1319</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>October 22, 1921</b>                              |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |
| Usual Residence of Decedent   |  |   |  |  |                                |   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Frostburg</b>  |                                |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>One Kaylor Circle</b>  |  |   |  | 10f. Zip Code<br><b>21532-</b>   |                                |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker Homemaker</b>  |                                |   |  | 16b. Kind of Business/Industry<br><b>homemaker</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edgar Weigand</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clarabelle Paul</b>  |                                |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard G. Snyder son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>316 Williams Street Cumberland Maryland 21502</b>  |                                |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forest Lawn Cemetery</b>   |  | Date<br><b>February 20, 2007</b>   |                                | 20c. Location - City or Town, State<br><b>Johnstown Pennsylvania</b>                        |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>  |                                |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>CARCINOMA LUNG</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>about 7 years</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |                                |   |  | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>   |  |   |  |  |                                |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  |  |                                | 29c. License number<br><b>D26907</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 19, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harjit Sidhu, M.D., 425 Bishop Walsh Rd., Cumberland, Maryland 21502</b>   |  |   |  |  |                                |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 2007</b>   |  |   |  | 32. Registrar's Signature<br>   |                                |   |  |   |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08238

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Charlotte Schaidt

2. Date of Death

Feb. 15, 2007

3. Time of Death

12:50 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

212-24-2000

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

04/24/1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

713 Interval Road, #R

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Edgar

18. Mother's Name (First, Middle, Maiden Surname)

Knapp

Sylvia

Hook

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Bible / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

713 Interval Road, #R, Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Vet. Cem. @ Rocky Gap

Date

02/20/2007

20c. Location - City or Town, State

Flintstone, MD

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of)

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of)

c. Pneumonia

Due to (or as a consequence of)

d.

Approximate Interval Between Onset and Death

6 hrs

30 yrs

6 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Wassem 1126 Opal Court 1479. MD 21740

31. Date filed (Month, Day, Year)

FEB 16 2007

32. Registrar's Signature

FEB 16 2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08239

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Joseph Stewart

2. Date of Death

Month Day Year  
FEBRUARY 26, 2007

3. Time of Death

08:30P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

214-16-8998

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 6, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21 Center Street, P.O. Box 4

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

one year

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Entomologist

16b. Kind of Business/Industry

Aberdeen Proving Ground

Aberdeen, Maryland

17. Father's Name (First, Middle, Last)

Joseph J. Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Johnson

19a. Informant's Name/Relationship (Type, Print)

Linda S. Robertson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3924 Bush Court, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris &amp; Co., Inc.

Date

03/06/07

20c. Location - City or Town, State

West Chester, Pennsylvania

21. Signature of Funeral Service Licensee

Thomas M. Patterson Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.  
Perryville, Maryland 21903-0766

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AORTIC STENOSIS

Due to (or as a consequence of):

UNKNOWN

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas S. Miller M.D.

29c. License number

D30272

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS S. MILLER, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

31. Date filed (Month, Day, Year)

MAR 2 2007

32. Registrar's Signature

Thomas S. Miller

NAME KNOWN TO PHYSICIAN: CLARENCE J. STEWART  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08240

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Nelson Santos</b>  |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>22</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>11:55aM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>227-51-7601</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>10/26/1957</b> | 9. Birthplace (State or Foreign Country)<br><b>Brazil</b>  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2507 Urbana Drive</b>  |  | 10f. Zip Code<br><b>20906</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Brazilian</b>   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>College (1-4or 5+)</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Shoe Shine Operator</b>   |  | 16b. Kind of Business/Industry<br><b>Shoe Shine Co.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Joaquin Ribeiro Dos Santos</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leopoldina Dos Santos</b>   |  | 19a. Informant's Name/Relationship (Type, Print) <b>Wife</b><br><b>Flavia Dias De Oliveira/</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2507 Urbana Drive Silver Spring, Md. 20906</b>   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crem</b>  |  | 20c. Location - City or Town, State<br><b>3/05/2007 Beltsville, Md.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>PHILIP D. RINALDI FUNERAL SERVICE, P.A.<br/>9241 Columbia Blvd. Silver Spring, Md 20910</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Pre-existing cardiac disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes 2 <input type="checkbox"/> No  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 62175</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Feb. 26, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S. Gupta MD 1500 Forest Glen Road Silver Spring, Md 20910</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2007</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08241

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 5052.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>David Corbly Townsend</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>13:43 M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>   |  |
| 5. Social Security Number<br><b>166 34 9529</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Apr 14, 1942</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Columbia</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>10765 Autumn Splendor Drive</b>   |  | 10f. Zip Code<br><b>21044</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b> |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Specialist</b>  |  | 16b. Kind of Business/Industry<br><b>Nat'l Security Agency</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Townsend</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Gregg</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna W. Townsend/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10765 Autumn Splendor Drive Columbia, MD 21044</b>                                   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3/2/2007 Catonsville, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Donna W. Townsend</b>  |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Amphotrophic lateral sclerosis</b>   |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 23d. Date of delivery<br>Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>James C. [Signature]</b>   |  | 29c. License number<br><b>D50973</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 1, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACOB CHICKAN MD 5450 Knoll North Dr. St 310 Columbia MD 21045</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND ITEM #1 per PHS, #10e per H 0866 4/3/07 VS  
State of Maryland / Department of Health and Mental Hygiene1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2007 08242

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

~~Saigzar Tirgari~~ Siagzar Tirgari

2. Date of Death

Month Day Year  
February 22, 2007

3. Time of Death

11:04 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

216-11-5574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 15, 1936

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18909 High Point ~~Drive~~ Road

10f. Zip Code

20879

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Caucasian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chemist

16b. Kind of Business/Industry

Environmental Health

17. Father's Name (First, Middle, Last)

Ahmad Tirgari

18. Mother's Name (First, Middle, Maiden Surname)

Akhar Moshiri

19a. Informant's Name/Relationship (Type, Print)

Mr. Saman Tirgari-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10500 Rockville Pike #G-21, Rockville, Maryland 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Cemetery

Date

02/26/2007

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Simple Tribute  
1040 Rockville Pike, Rockville, Maryland 2085223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

22 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43083

29d. Date signed (Month, Day, Year)

February 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, M.D. 9707 Medical Center Drive, #300 Rockville, MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Amend Items 23e, 24a, b, 25, 26, 27, 29a per dr. #865.03/15/07/11b

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WAH GET WONG

2. Date of Death

Month

Day

3. Time of Death

Feb

23

Year

3:39 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hosp.

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

025-20-6237

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec

24

1923

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1135 West University Blvd

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Chinese

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Yeshiba College

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Donetha Wong (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip)

1135 University Blvd, #912, Silver Spring, MD 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Riverdale

Crematory

Date

3/3/07

20c. Location - City or Town, State

Riverdale, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850  
246 N. Washington St, Rockville, Md

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Approximate  
Interval Between  
Onset and Death

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0060100

29d. Date signed (Month, Day, Year)

02-23-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

831 University Blvd East Silver Spring MD 20903

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08244

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna

Pauline

Wright

2. Date of Death

Month Day Year  
February 14, 2007

3. Time of Death

11:30 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

13118 Bedford Road, NE

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

236-48-3205

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01/21/1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13118 Bedford Road, NE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Arthur

Dinges

Godlove

18. Mother's Name (First, Middle, Maiden Surname)

Tircie

Ellen

Wilson

19a. Informant's Name/Relationship (Type, Print)

John E. Wright / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13118 Bedford Road, NE., Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

02/18/2007

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic lung cancer

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46346

29d. Date signed (Month, Day, Year)

February 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 16 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08245

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>Trilba Juanita Wagoner  |  | 2. Date of Death<br>Month Day Year<br>February 14, 2007   |   | 3. Time of Death<br>1930 P M  |  |
| 4a. Facility Name (If not institution, give street and number)<br>Allegany County Nursing & Rehab Ctr.  |  | 4b. City, Town, or Location of Death<br>Cumberland  |   | 4c. County of Death<br>Allegany   |  |
| 5. Social Security Number<br>220-30-8376  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>74 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>08/09/1932 | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |
| Usual Residence of Decedent   |  |   |   |   |  |
| 10a. State<br>WV  | 10b. County<br>Mineral   | 10c. City, Town or Location<br>Fort Ashby   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br>Route 963, Wagoner Road (P.O.Box 671)   |  | 10f. Zip Code<br>26719  |   | 10g. Citizen of What Country?<br>USA  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12  |   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |  | 16b. Kind of Business/Industry<br>Medical   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Arthur Eugene Whisner  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel (NMN) McCoy  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Alden E. Wagoner / husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 671, Fort Ashby, WV 26719   |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Restlawn Mem. Gardens   |   | 20c. Location - City or Town, State<br>LaVale, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert C. Adams</i>   |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Coronary artery Disease 10 yrs.   |  |   |   |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>- Renal failure<br>- Diabetes Mellitus   |  |   |   |   |  |
| 23c. If female, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>P 0033280  |  |
| 29d. Date signed (Month, Day, Year)<br>Feb 15, 2007   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sunil Gupta, M.D., 625 Kent Avenue, Cumberland, MD 21502  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 16 2007  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08246

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Velda Ware

2. Date of Death

February 28 2007

3. Time of Death

10:30 P M

4a. Facility Name (If not institution, give street and number)

Charlestown

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

228 14 4526

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

8. Date of Birth

Jan 27, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15617 Holly Grove Road

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Howard Ward Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Lee Sibley

19a. Informant's Name/Relationship (Type, Print)

John Ware/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15617 Holly Grove Road Silver Spring, MD 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3-1-2007

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

John Collins - Witzke

M01044

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, dysphagia from old stroke

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adam W

29c. License number

P0020040

29d. Date signed (Month, Day, Year)

3/1/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adam W 711 Maiden Chance Cnwy Catonsville, MD

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Adam W

21228

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08247

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Walters

2. Date of Death

March 1, 2007

3. Time of Death

5:05 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

4b. City, Town, or Location of Death

Braddock Heights

4c. County of Death

Frederick

5. Social Security Number

213-22-3990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 1, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

414 9th Avenue

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Biology Technician

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Thomas Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Diehl

19a. Informant's Name/Relationship (Type, Print)

Sherman Wigfield - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

420 9th Avenue, Brunswick, Maryland 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Blue Ridge Memorial

Date

3-7-2007

20c. Location - City or Town, State

Roanoke, Virginia

21. Signature of Funeral Service Licensee

*Sharon L. L. L.*

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Caroline Gessert*

29c. License number

MD056890

29d. Date signed (Month, Day, Year)

3/2/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caroline Gessert 610 9th Avenue Brunswick MD 21716

31. Date filed (Month, Day Year)

MAR 02 2007

32. Registrar's Signature

*Heaven H. Apple*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08248

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Olga N. Yursis</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>28</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>8:00 A<sup>M</sup></b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5516 Barrington Court</b>   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   | 4c. County of Death<br><b>Howard</b>   |  |
| 5. Social Security Number<br><b>214 43 7871</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>July 23, 1954</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Ukraine</b> |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Columbia</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>5516 Barrington Court</b>   |  | 10f. Zip Code<br><b>21045</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>  |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Retail</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Andrei Nazarenko</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tatiana Zagornaya</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Steve Elville/PR</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21044 Reese &amp; Carney 10715 Charter Dr. Ste 200 Columbia, MD</b>  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |   | 20c. Location - City or Town, State<br><b>3-1-2007 Catonsville, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Sam Collins - Witzke</b>   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Uterine Sarcoma</b>  |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br><b>6 months</b>  |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |   | 23d. Date of delivery<br>Month Day Year  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Sam Collins - Witzke</b>   |  | 29c. License number<br><b>241139</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 1, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Clement B. Knight, MD 11065 Little Patuxent Pkwy Columbia MD 21044</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |  | 32. Registrar's Signature<br><b>Sam Collins - Witzke</b>  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08249

1- For  
State  
Registrar

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Walter Ash</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MAR 06 2007</b>  |  | 3. Time of Death<br><b>0555AM</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST AGNES HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-40-0866</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 10, 1942</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>400 Millington Avenue</b>  |  | 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |
| To Be Completed by Funeral Director           | 15. Decedent's Education (Specify only highest grade completed)<br><b>8</b> Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>cab driver</b>  |  | 16b. Kind of Business/Industry<br><b>transportation</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Ash</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Hienlein</b>  |  |   |  |
| To Be Completed by Funeral Director           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Goldie McNamara/sister</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>820 Caton Avenue #9K Baltimore, MD 21229</b>  |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify) <b>in state</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State   |  |   |  |
| To Be Completed by Funeral Director           | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPOXIC ENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br><b>CARDIOPULMONARY ARREST WITH CPR</b><br>Due to (or as a consequence of):<br><b>SMALL BOWEL OBSTRUCTION</b><br>Due to (or as a consequence of):<br><b>INCARCERATED VENTRAL HERNIA</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>7 days</b><br><b>9 days</b><br><b>MONTHS</b>                                  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No<br><b>9</b> Unknown  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DILATED CARDIOMYOPATHY</b><br><b>DIABETES MELLITUS</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                             |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)            |  |   |  |   |  |
|   | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br><b>Manish Singh</b>  |  | 29c. License number<br><b>A524385283699</b>                             |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>MAR, 06, 2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MANISH SINGH, ST. AGNES HOSPITAL 9005 CATON AVE BALTIMORE</b>                                    |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><b>Manish Singh</b>  |  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**

2007 08250

1- For State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| Physician/<br>Medical Examiner  | 1. Decedent's Name (First, Middle, Last) <b>Reuben E. Alley, Jr.</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>8</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>2325 hrs</b>  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>299 Halsey Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>229-16-4417</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days Hours Min.                   | 8. Date of Birth (MM/DD/YYYY)<br><b>July 16, 1918</b>  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |   |  |
|   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Annapolis</b>             |  |
|   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |
|   | 10e. Street and Number<br><b>299 Halsey Road</b>   |  | 10f. Zip Code<br><b>21401</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>44-46</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>college professor</b>   |   | 16b. Kind of Business/Industry<br><b>education</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Reuben Edward Alley</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Sutherland</b>   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Alley/son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 Tanglewood Drive Barrington, RI 02806</b>   |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | 20c. Location - City or Town, State  |
| 21. Signature of Funeral Service Licensee<br><i>Ronald S. Wade</i> Director   |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |   |   |  |
| Physician<br>Medical Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Smoke inhalation</b>           |  |   |   | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):  |  |   |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |
|   | Due to (or as a consequence of):   |  |   |   |  |
|   | Due to (or as a consequence of):   |  |   |   |  |
|   | Due to (or as a consequence of):   |  |   |   |  |
|   | <input type="checkbox"/> UNPENDED<br><input checked="" type="checkbox"/> AMENDED<br><b>#1, per ME, G865, 3/16/07 TT</b>  |  |   |   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Mar 8, 2007</b>  |   | 28b. Time of Injury<br><b>FOUND: 2325 hrs</b>               |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Victim of house fire</b>   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Single Family</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>299 Halsey Road, Annapolis, MD</b>  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>ling li, MD</i>   |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 9, 2007</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |  |   |   |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |

Baltimore, MD 21215-0036

Physician  
Medical Examiner

**Division of Vital Records, P.O. Box 68760,**  
**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08251

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Helene Alley

2. Date of Death  
Month Day Year  
March 9, 20073. Time of Death  
1108 hrs

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

143-16-2074

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Mar 8, 1919

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

299 Halsey Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

Specify: white

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

medical secretary

16b. Kind of Business/Industry

healthcare

17. Father's Name (First, Middle, Last)

Theodore Whitlock

18. Mother's Name (First, Middle, Maiden Surname)

Clara Ethel Werner

19a. Informant's Name/Relationship (Type, Print)

Robert Alley/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Tanglewood Drive Barrington, RI 02806

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval  
Between Onset and  
Death

Immediate Cause (Final disease or condition resulting in death)

a. Thermal injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

☐ UNPENDED☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☒ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Mar 8, 2007

28b. Time of Injury

FOUND: 2325 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject victim of house fire

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Single Family Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

299 Halsey Road, Annapolis, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 10, 2007

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Ronald S. Wade

Baltimore, MD 21215-0036

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08252

1- For State Registrar

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician / Medical Examiner                  | 1. Decedent's Name (First, Middle, Last)<br><b>ELSA ANDERSON</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>11</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>2:55 P. M</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FOREST HILL HEALTH &amp; REHABILITATION</b>  |  | 4b. City, Town, or Location of Death<br><b>FOREST HILL</b>  |  | 4c. County of Death<br><b>HARFORD</b>  |
| Funeral Director                              | 5. Social Security Number<br><b>077-03-1927</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 27, 1915</b> | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
|   | Usual Residence of Decedent   |  |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Bel Air</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>1209 Bartus Court</b>  |  | 10f. Zip Code<br><b>21014</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4or 5+) <b>College</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Gustov Lundstrom</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Monsun</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alan Anderson (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1209 Bartus Court Bel Air, Maryland 21014</b>   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>  |  | 20c. Location - City or Town, State<br><b>03/16/2007 Baltimore, Maryland</b>   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, Md. 21014</b>  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebral vascular accident</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown       |  | 23d. Date of delivery<br>Month Day Year  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|   | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>032255</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH, 12, 2007</b>  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br>   |  |  |
|   | State Registrar   |  |   |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 19

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08253

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Michael Amasia

2. Date of Death

Month Day Year  
March 7, 2007

3. Time of Death

11:00 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

2823 Cross Country Ct.

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212-30-0761

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 29, 1914

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Harford10c. City, Town or Location  
Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2823 Cross Country Ct.

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Martin Marietta

17. Father's Name (First, Middle, Last)

Andrea Amasia

18. Mother's Name (First, Middle, Maiden Surname)

Filomena Veniero

19a. Informant's Name/Relationship (Type, Print)

Andrea Amasia (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2300 Oakmont Road, Fallston, MD 21047

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkview Mausoleum

Date

3/12/2007

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

B. A. Miller

22. Name and Address of Facility

Schimunek Funeral Homes  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Aspiration Pneumonia

Approximate Interval Between Onset and Death

&gt; 1wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Poor Pulmonary Toilet secondary to

22 1/2 yrs

c. Severe Left COPD with right sided pneumonia

22 1/2 yrs

d. Abundant fibrin clots without anti-coagulation

&gt; 5 yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pagets Disease of Bone  
ischemic colitis with subtotal resection  
of colon 2003;

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael D. Miller MD

29c. License number

D0027093

29d. Date signed (Month, Day, Year)

3/9/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael D. Miller MD 4530 Walther Ave Baltimore MD 21206

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

B. A. Miller

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08254

1- For  
State  
Registrar

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Josephine A. Bush</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>12:15 P<sup>M</sup></b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7148 Martell Avenue</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-36-3212</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1938</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Dundalk</b>   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>7148 Martell Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 years</b> College (1-4 or 5+) <b>Housewife</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Our Home</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Everett R. Smith</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie C. Siwak</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Howard Bush husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7148 Martell Avenue, Dundalk, Maryland 21222</b>   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA.</b>  |  | 20c. Location - City or Town, State<br><b>March 21, 2007 Owings Mills, MD.</b>   |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk, P.A.<br/>7110 Sollers Point Road, Dundalk, MD. 21222</b> |  |
| To Be Completed by Physician/Medical Examiner | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC BREAST CANCER</b><br>Due to (or as a consequence of):<br>b. <b>BRAIN METASTASES</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2 1/2 years</b><br><b>2 1/2 years</b> |  |   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  |
|   | 29c. License number<br><b>D33551</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 16, 2007</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. FUERBACH, 9110 Philadelphia Rd #314, Baltimore, MD 21237</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  | 33. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08255

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOIS BOLDEN

2. Date of Death

Month 3 Day 8 Year 2007

3. Time of Death

5:45 A-M

4a. Facility Name (If not institution, give street and number)

Future Care Sandtown

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

129-18-2581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 23, 1922

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1811 E. Baltimore Street

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4or 5+)

unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

waitress

16b. Kind of Business/Industry

restaurent

17. Father's Name (First, Middle, Last)

John Devode

18. Mother's Name (First, Middle, Maiden Sumame)

Bethea Grant

19a. Informant's Name/Relationship (Type, Print)

Amona Marshall/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1811 E. Baltimore Street Baltimore, MD 21231

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Small Cell lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)3 ☐ Ectopic pregnancy

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Anemia

Malnutrition

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0061439

29d. Date signed (Month, Day, Year)

03/08/07

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ADOLEMIA, SUSAN M, MD 2600 LIBERTY HEIGHT AVE, BALTIMORE, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08256

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOEL

BITMAN

2. Date of Death

MARCH 06, 2007

3. Time of Death

1230 PM

4a. Facility Name (If not institution, give street and number)

BROOKE GROVE REHABILITATION AND NURSING

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

150-20-4049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 29, 1926

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Sandy Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18131 Slade School Road

10f. Zip Code

20860

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 44-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

biochemist

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

Charles Bitman

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Winnick

19a. Informant's Name/Relationship (Type, Print)

Doreen Bitman/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1403 Sarah Drive Silver Spring, MD 20904

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE RENAL FAILURE

ONE WEEK

Due to (or as a consequence of):

b. DYSPHAGIA

SIX WEEKS

Due to (or as a consequence of):

c. FRONTOTEMPORAL CEREBROVASCULAR  
ACCIDENT

SIX WEEKS

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE; TYPE 2 DIABETES

MELTUS; ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. M. HOFFMAN ATTENDING PHYSICIAN

29c. License number

1D42046

29d. Date signed (Month, Day, Year)

MARCH 07, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROOKE HOFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00257

1- For State Registrar

Physician/  
Medical ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ANTHONY ANDRE BRYAN</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>9</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>1540 hrs</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>University Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>220-80-4247</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>37</b> Yrs.   |  |
| 8. Date of Birth (MM/DD/YYYY)<br><b>07/28/1969</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1006 N. ELLAMONT STREET</b>  |  | 10f. Zip Code<br><b>21216</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |  | 16b. Kind of Business/Industry<br><b>AMSEM METAL BUILDING CO.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIE JOHN BRYAN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL PARKER</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>STACYE B. SPEIGHT/SISTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6000 AMBERWOOD RD, BALTIMORE, MD 21206</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEM.</b>  |  | 20c. Location - City or Town, State<br><b>LANSDOWNE, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD</b>  |  |  |  |
| 23. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death) a. <b>Gunshot Wound of Head</b>  |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:          |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Mar 9, 2007</b>  |  | 28b. Time of Injury<br><b>0856 hrs</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Subject shot</b>  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3001 Rosedale Court, Baltimore, MD</b>   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Pamela E. Southall, MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

Baltimore, MD 21215-0036

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08258

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence

Busby

2. Date of Death

Month

Day

Year

03

11

2007

3. Time of Death

1:28p M

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-12-4381

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

07

22

12

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2206 West Lanvale Street

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th gradeCollege (1-4or 5+)  
na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Peter White

18. Mother's Name (First, Middle, Maiden Surname)

Josephine White

19a. Informant's Name/Relationship (Type, Print)

Victor Busby-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8339 Arbor Station Way Apt L, Parkville, Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Nat'l 3/15/07

Date

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Sela March

22. Name and Address of Facility

March F/H West  
4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEMORRHAGIC STROKE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sela March

29c. License number

D060560

29d. Date signed (Month, Day, Year)

MARCH 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANKAJ KHESTERPAL 201, BACK RIVER NECK RD #109, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

James J. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21260-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08259

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT BARBER

2. Date of Death

03 07 2007

3. Time of Death

755 PM

4a. Facility Name (If not institution, give street and number)

Bluepoint Nsg &amp; Rehab

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

Funeral  
Director

5. Social Security Number

214-56-9036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/10/1951

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2725 Winchester St.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Albert Gaines

18. Mother's Name (First, Middle, Maiden Surname)

Sara Barber

19a. Informant's Name/Relationship (Type, Print)

Trina Hall/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2126 Westbourne Dr. Creedmoor, NC 27522

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory Inc. 2007

Date

Mar 16

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Trina Hall

22. Name and Address of Facility

Cremation and Funeral Alternatives  
8717 Green Pastures Drive Baltimore, Maryland 21286-

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer Pancreas with metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition  
Chronic Pain

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Trina Hall

29c. License number

D96748

29d. Date signed (Month, Day, Year)

3/8/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL UBEAU 4419 FALLS RD BALTO MD 21211

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Trina Hall

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08260

|   |  |   |   |                                      |  |   |   |  |  |  |
|---|--|---|---|--------------------------------------|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Basil Bianconi</i>  |   |   |                                      | 2. Date of Death<br>Month <i>March</i> Day <i>14</i> Year <i>2007</i>  |   |   |  | 3. Time of Death<br><i>6 PM</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Genesis - Perryway Parkway</i>  |   |   |                                      | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |   |   |  | 4c. County of Death<br><i>Baltimore City</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>212 01 4177</i>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><i>94</i> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><i>8/22/1912</i>     |  | 9. Birthplace (State or Foreign Country)<br><i>MARYLAND</i>  |  |
|   | Usual Residence of Decedent  |   |   |                                      |  |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><i>MD</i>  |   | 10b. County<br><i>BALTIMORE</i>   |                                      | 10c. City, Town or Location<br><i>PARKVILLE</i>  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><i>2907 WILLOUGHBY ROAD</i>  |   |   |                                      | 10f. Zip Code<br><i>21234</i>  |   | 10g. Citizen of What Country?<br><i>USA</i>                 |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+) <i>0</i>  |   |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>SHEET METAL FABRICATION SHEET METAL</i>  |   |   |  | 16b. Kind of Business/Industry   |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>ROMEO BIANCONI</i>   |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>AUSSUNTA COSENTINO</i>   |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>RICHARD BIANCONI / SON</i>  |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21218 4208 N. CHARLES STREET UNIT 4 BALTO. MD.</i>  |   |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>PARKWOOD CEMETERY</i>  |                                      | Date<br><i>3/21/07</i>   |   | 20c. Location - City or Town, State<br><i>BALTIMORE, MD</i> |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |                                      | 22. Name and Address of Facility<br><i>CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MARYLAND 21237</i>  |   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Pneumonia</i><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                      |  |   |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown |                                      |  |   | 23d. Date of delivery<br>Month Day Year                     |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia</i>  |  |   |   |                                      |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                                      |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                      |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><i>M</i>      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                      |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |                                      |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Wendy Klay MD</i>   |  |   |   | 29c. License number<br><i>D31295</i> |  | 29d. Date signed (Month, Day, Year)<br><i>MARCH 15, 2007</i>                                    |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Wendy Klay MD 6701 N Charles St Suite 4202 Towson MD 21204</i>   |  |   |   |                                      |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 16 2007</i>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |                                      |  |   |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08261

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alma M. Bauer

2. Date of Death

Month Day Year  
March 13, 2007

3. Time of Death

3:35p M

4a. Facility Name (If not institution, give street and number)

Riverview Nursing Center

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-01-0603

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 16, 1911

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1000 Franklin Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Lord Baltimore Press

17. Father's Name (First, Middle, Last)

Fredrick Deshner

18. Mother's Name (First, Middle, Maiden Surname)

Cora McLaughlin

19a. Informant's Name/Relationship (Type, Print)

Rayna Thormann / niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Francis Green Circle Balto. MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

3/16/07

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Robert J. Connelly Jr.

22. Name and Address of Facility

300 Mace Ave. Balto. MD  
Connelly Funeral Home of Essex 2122123a. Part I. Enter the disease and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Loh

29c. License number

H 35593

29d. Date signed (Month, Day, Year)

3/14/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John Loh 1124 Mace Ave, Baltimore, MD 21221

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

John Loh

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eunice Church Barker

2. Date of Death  
Month Day Year  
March 12 20073. Time of Death  
8:30 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

8455 Murphy Road

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

5. Social Security Number

239-07-3042

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 9 1910

9. Birthplace (State or Foreign  
County)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8455 Murphy Road

10f. Zip Code

20703

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

owned home

17. Father's Name (First, Middle, Last)

Pink Church

18. Mother's Name (First, Middle, Maiden Surname)

Sarah N Church

19a. Informant's Name/Relationship (Type, Print)

Victoria Sessler, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12363 Pleasant View Drive Fulton MD 20759

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodland Cemetery

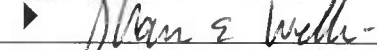
Date

3/15/2007

20c. Location - City or Town, State

Winston-Salem, North Carolina

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fleck Funeral Home

7601 Sandy Spring Rd Laurel MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Advanced Dementia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death  
years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) group home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D51860

29d. Date signed (Month, Day, Year)

3/15/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Fish MD 10700 Charter Drive Suite 200 Columbia MD 21044

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08263

1- For  
State  
Registrar

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Warner Brown   |   |   | 2. Date of Death<br>Month 3 Day 13 Year 2007   |  | 3. Time of Death<br>6:45 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1945 Drew Street   |   |   | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-24-5952   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>76 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>May 30, 1930  |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND             |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   | 10b. County<br>ANNE ARUNDEL   | 10c. City, Town or Location<br>ANNAPOLIS  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>1945 DREW STREET   |   |   | 10f. Zip Code<br>21401   |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: UNK |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MAINTENANCE REPAIR FEDERAL GOV'T         |  | 16b. Kind of Business/Industry   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>THOMAS NORWOOD BROWN  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>REBA HURDLE   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>DENISE ALLEN   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7908 DARIEN DRIVE GLEN BURNIE, MD 21061 |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HILLCREST   |  | 20c. Location - City or Town, State<br>3/17/2007 ANNAPOLIS, MD   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br>MILLER'S METROPOLITAN CHAPEL 1922 Forest Dr.  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Kidney cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 years |   |   |  |  |  |  |
|   | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year       |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>D0064379  |  | 29d. Date signed (Month, Day, Year)<br>3/13/07   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jay Rhee 900 Bestgate Rd Suite 300 Annapolis MD 21401   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 16 2007  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08264

|  |   |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Wilhelm J. Brzuchalski</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>2:00 P M</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Keswick Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>212-76-0976</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 9, 1927</b>                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>930 Kinwat Avenue</b>  |  | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>None</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never Worked</b>                  |  | 16b. Kind of Business/Industry  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Adam M. Brzuchalski</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Haluch</b>  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wanda Carlton (Sister)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>930 Kinwat Avenue, Baltimore, Maryland 21221</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>03/12/2007 Glen Burnie, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Bruce D. Fin</b>                            |  |
| To Be Completed by<br>Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213</b>  |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CEREBROVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 23d. Date of delivery<br>Month Day Year   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by<br>Physician/Medical Examiner | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Kendall R. Faulkner</b>   |  |   |  | 29c. License number<br><b>D25643</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/9/07</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kendall Faulkner, 700 W. 40th St., Baltimore, Maryland 21211</b>   |  |   |  |   |  |   |  |
| State<br>Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |  | 32. Registrar's Signature<br><b>Kendall R. Faulkner</b>   |  |   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08265

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Alexander Kirkland Barton</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>6:55 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Blakehurst Life Care Community</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>212-20-3617</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>February 14, 1923</b>  | 9. Birthplace (State or Foreign Country)<br><b>California</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Towson</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>1055 W. Joppa Rd.</b>   |  | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>insurance broker</b>  |  | 16b. Kind of Business/Industry<br><b>insurance</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alexander Kirkland Barton</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaretta Ankarcrona</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cary Lee Barton/wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1055 W. Joppa Rd. Towson, MD 21204</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Mar. 13, 2007 Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>John O. Mitchell II</b>  |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home, Inc.<br/>6500 York Rd. Baltimore, MD 21212</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Prostate Cancer</b><br>Approximate Interval Between Onset and Death<br><b>Months</b>  |  |   |  |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>  |  | 29c. License number<br><b>D58303</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 12 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Arnon J. Charles MD 6701 N. Charles St Baltimore MD 21204</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08266

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

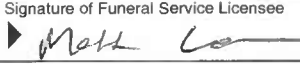
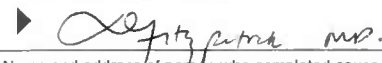
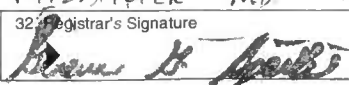
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
|---|----------------------------------|---|--|--|--|-------------------------------|----------------------------------|--------------------------------|----------------------------------|----|----------------------------------|----|----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>HILDA BLANS</b>  |                                  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>13</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>0953 AM</b>   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>   |                                  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 5. Social Security Number<br><b>160-01-9007</b>   |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 8. Date of Birth (Month, Day, Year)<br><b>06/25/1913</b>  |                                  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| Usual Residence of Decedent   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 10a. State<br><b>MD</b>   |                                  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 10e. Street and Number<br><b>725 MT. WILSON LANE APT. #333</b>  |                                  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 17. Father's Name (First, Middle, Last)<br><b>HYMAN MILLER</b>  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNY GREEN</b>   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHEILA BONNELL / DAUGHTER</b>  |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4042 CARTHAGE ROAD - RANDALLSTOWN, MD 21133</b>   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH EL MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>03/14/2007 RANDALLSTOWN, MD</b>  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 21. Signature of Funeral Service Licensee<br>  |                                  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| Immediate Cause (Final disease or condition resulting in death)   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| <table border="0"> <tr> <td>a. <b>respiratory failure</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>aspiration pneumonia</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>  |                                  |   |  |  |  | a. <b>respiratory failure</b> | Due to (or as a consequence of): | b. <b>aspiration pneumonia</b> | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
| a. <b>respiratory failure</b>   | Due to (or as a consequence of): |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| b. <b>aspiration pneumonia</b>  | Due to (or as a consequence of): |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| c.  | Due to (or as a consequence of): |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| d.  | Due to (or as a consequence of): |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| Approximate Interval Between Onset and Death  |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |                                  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown     |  | 23d. Date of delivery<br>Month Day Year  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
|   |                                  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
|   |                                  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |                                  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
|   |                                  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
|   |                                  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 29b. Signature and title of certifier<br>  |                                  | 29c. License number<br><b>D00549736</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 13, 2007</b>   |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEBORAH WATSON FITZPATRICK MD NORTHWEST HOSPITAL 5401 OLD COURT ROAD</b>   |                                  |   |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |                                  | 32. Registrar's Signature<br>  |  |  |  |                               |                                  |                                |                                  |    |                                  |    |                                  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08267

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MYRA

BIEDERMAN

2. Date of Death

Month  
MARCH

Day

12

Year

2007

3. Time of Death

6:05 P M

4a. Facility Name (If not institution, give street and number)

GLADE VALLEY NURSING &amp; REHAB CENTER

4b. City, Town, or Location of Death

WALKERSVILLE

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

052-16-1250

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

8. Date of Birth

If Under 1 Year  
Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07/20/1920

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

FREDERICK

10c. City, Town or Location

WALKERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

56 WEST FREDERICK STREET

10f. Zip Code

21793-8254

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE

SCHEFLIN

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE

HANSON

19a. Informant's Name/Relationship (Type, Print)

WENDY CIBELLI / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2611 MONOCACY FORD ROAD - FREDERICK, MD. 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH DAVID

Date

03/14/2007

20c. Location - City or Town, State

ELMONT, NY

21. Signature of Funeral Service Licensee

Scott M. Little

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Right Occipital Meningioma (Recurrent)

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right Occipital Meningioma - recurred 1998

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen J. Gilson

29c. License number

D26516

29d. Date signed (Month, Day, Year)

MARCH 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLEN J GILSON MD 1475 TANEY AVE FREDERICK MD 21702

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Allen J. Gilson

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08268

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julius Conway

2. Date of Death

Month

Day

Year

3. Time of Death

03

14

07

1213 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

406-24-8300

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
06/22/29

9. Birthplace (State or Foreign Country)

KY

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5017 Eliot Oak Road

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Systems Manager

16b. Kind of Business/Industry

Northrop Grumman

17. Father's Name (First, Middle, Last)

Julius Conway, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Clara Booker

19a. Informant's Name/Relationship (Type, Print)

W. Ruth Conway (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5017 Eliot Oak Rd., Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

Cemetery or other place)

Lucust Grove Meth Church Cemetery

Date

3/20/07

20c. Location - City or Town, State

Columbia, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and address of Facility

Vaughn C. Greene Funeral Services  
5151 Balto Nat'l Pike, Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Essential Hypertension

Due to (or as a consequence of):

c. Hyperlipidemia

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type 2 Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandra Harstgen 3100 Wymon Park Dr. Baltimore, MD 21211

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

15

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08269

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |                                 |   |   |   |   |   |
|--|--|--|--|---|--|---------------------------------|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Christopher S. Cook</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>03-14-2007</b>  |                                 |   |   | 3. Time of Death<br><b>10:30 PM</b>                                     |   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Ritchie Hospice</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                 |   |   | 4c. County of Death   |   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-64-9765</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |   | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>09-24-1955</b>      |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                   |   |   |
|  | 10a. State<br><b>MD</b>  |  |  |   | 10b. County<br><b>Baltimore</b>  |                                 |   |   | 10c. City, Town or Location<br><b>Baltimore</b>                         |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>700 Edmonson Avenue</b>   |  |  |   | 10f. Zip Code<br><b>21228</b>  |                                 |   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |   |
|  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                 |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>College</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Mechanic</b>                  |                                 |   |   | 16b. Kind of Business/Industry<br><b>Automotive</b>                     |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Cook</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gloria Dorsey</b>  |                                 |   |   |   |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Regina R. Cook (Wife)</b>   |  |  |   | 19b. Mailing Address (Street and Number, Rural Route Number, City or Town, State, Zip Code)<br><b>700 Edmonson Ave. Balt. MD 21228</b>             |                                 |   |   |   |   |   |
|  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bushy Park</b>            |   | 20c. Date<br><b>3/21/07</b>  |                                 | 20d. Location - City or Town, State<br><b>Sylkesville, MD</b> |   |   |   |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>   |  |  |   | 22. Name and Address of Facility<br><b>Vaughn C. Greene Funeral Service<br/>5151 Balt. Nat'l Pike, Balt., MD 21229</b>                             |                                 |   |   |   |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Carcinoma of larynx with mets over 1 year</b> |  |  |   | Approximate Interval Between Onset and Death   |                                 |   |   |   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Due to (or as a consequence of):</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>                             |  |  |  |   |  |                                 |   |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No <b>9</b> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown                                |  |                                 |   | 23d. Date of delivery<br>Month Day Year   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |                                 |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |                                 |   |   |   |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>Hospice</b> |  |                                 |   |   |   |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   | 28d. Describe how injury occurred                     |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br><b>John W. Payne MD</b>  |  |                                 |   | 29c. License number<br><b>D13012</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/15/07</b> |   |
| 30. Name and address of person to be notified of cause of death (Item 23a) (Type, Print)<br><b>John W. Payne 4311 Underwood Rd Baltimore, MD 21218</b>   |  |  |  |   |  |                                 |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |                                 |   |   |   |   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08270

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Carper

2. Date of Death

Month Day Year  
February 26, 2007

3. Time of Death

2345 hrs

4a. Facility Name (if not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

unk

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24Hrs.

8. Date of Birth (MM/DD/YYYY)

July 28, 1955

9. Birthplace (State or Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

603 Holy Cross Road

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)

unk unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other Specify: in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Narcotic intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, 28a-f, per ME, g865, 3/17/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☒ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 2/25/2007

28b. Time of Injury

unk

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

house

28f. Location (Street and Number or Rural Route Number, City or Town, State)

603 Holy Cross Rd. Brooklyn, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio MD.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 2, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Physician  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08271

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence E. Carter

2. Date of Death

March 1, 2007

3. Time of Death

3:04 AM M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

231-30-0191

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 28, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

909 D Royal Street

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Anne Arundel Medical Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 Medical Parkway Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Head and Neck Cancer

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. DeVore MD

29c. License number

D01852

29d. Date signed (Month, Day, Year)

2 MARCH 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville, MD 20781

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

John B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08272

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
DOLORES COATES2. Date of Death  
Month Day Year  
FEB. 11 20073. Time of Death  
5:11P MFuneral  
Director4a. Facility Name (If not institution, give street and number)  
14 N. MORLEY STREET4b. City, Town, or Location of Death  
BALTIMORE CITY4c. County of Death  
N/A5. Social Security Number  
217-26-08826. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
78 Yrs.8. Date of Birth (Month, Day, Year)  
02/23/19299. Birthplace (State or Foreign Country)  
MARYLAND

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A10c. City, Town or Location  
BALTIMORE CITY10d. Inside City Limits  
1 ☒ Yes 2 ☐ No10e. Street and Number  
14 N. MORLEY STREET10f. Zip Code  
2122910g. Citizen of What Country?  
USA11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: BLACK15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4or 5+)  
12TH16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
COOK16b. Kind of Business/Industry  
FOOD SERVICE17. Father's Name (First, Middle, Last)  
WEBSTER THOMAS18. Mother's Name (First, Middle, Maiden Surname)  
ELIZABETH TRUSTY19a. Informant's Name/Relationship (Type, Print)  
MELVIN GREEN/ PERSONAL REP.19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
2701 W. BALTIMORE ST., BALTIMORE, MD 2122820a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Loudon Park Cem.Date  
3/17/0720c. Location - City or Town, State  
BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
HOWELL FUNERAL HOME 21207  
4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause of death.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Hypertension  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)27. Manner of Death  
1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number  
D005964829d. Date signed (Month, Day, Year)  
March 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sally Garrett-Ray, MD 4538 Edmonson Avenue, Baltimore, MD 21229

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 16 2007

Sally Garrett-Ray

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar


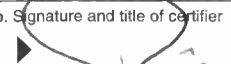
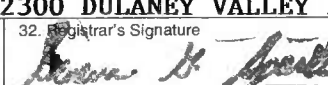
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08273

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JANE KENNEDY COMBER</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>10:05 A.M.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>216-24-7479</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>April 14, 1928</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Timonium</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2525 Pot Spring Road Apt. S-607</b>   |  | 10f. Zip Code<br><b>21093</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |
| 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Edward George Kennedy</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Catherine Drechsler</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas F. Comber, 3rd. (Husband)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21093 2525 Pot Spring Road Apt. S-607 Timonium, Maryland</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary of the Assumption Ch. Cem. 3-17-07 Baltimore, Maryland</b>   |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>BREAST CANCER</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |
| 28c. Describe how injury occurred  |  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D43725</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/13/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

State  
Registrar

MARCH 13, 2007 10:05 a.m.

JANE COMBER

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08274

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Lorraine Dodson

2. Date of Death

Month Day Year  
February 28, 2007

3. Time of Death

01:40 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

224-34-8610

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 19, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

160 Konred Morgan Way

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Zollie J. Kuser

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Fleming

19a. Informant's Name/Relationship (Type, Print)

Jackie Lambert - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

160 Konred Morgan Way Lothian, MD 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Panorama Memorial Gardens

Date

03/03/07

20c. Location - City or Town, State

Waterlick, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Turner-Robertshaw Funeral Home  
1200 N. Shenandoah Ave. Front Royal, 22630

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. URINARY TRACT INFECTION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HYPERTENSION

HIP FRACTURE - OSTEOPOROSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58900

29d. Date signed (Month, Day, Year)

FEBRUARY 28 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julia L. Surratt 100 Hospital Rd. Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- **Amend Item 2** State of Maryland / Department of Health and Mental Hygiene  
 Registrar per dr., 8865, 03/29/07 **Certificate of Death** Reg. No. 2007 08275

|   |  |   |   |  |  |  |   |
|---|--|---|---|--|--|--|---|
| <b>Physician / Medical Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Evans</b>  |   |   | 2. Date of Death <b>03/06/2007</b><br>Month <b>5</b> Day <b>6</b> Year <b>07</b>   |  | 3. Time of Death<br><b>8:45 PM<sup>M</sup></b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Healthcare (Commercial)</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| <b>Funeral Director</b>   | 5. Social Security Number<br><b>217-26-6464</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 6, 1929</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>             |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>8556 Oakleigh Road</b>  |   |   | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>telephone operator</b>  |  |  | 16b. Kind of Business/Industry<br><b>communications</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Elmore</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Viola Price</b>   |  |  |   |
| <b>To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Kellar/daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4534 Whetstone Court Hampstead, MD 21074</b> |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |   |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                       |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer Metastatic to Brain</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  | Approximate Interval Between Onset and Death                            |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive lung disease</b>   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Ziad Mirza</b>  |  |   |   | 29c. License number<br><b>0541901</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-7-2007</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ziad Mirza MD, 6701 N. Charles St, Towson, MD 21204</b>  |  |   |   |  |  |  |   |
| <b>State Registrar</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Amend #4c Per PHX G765 3/20/07 JH

Certificate of Death

Reg. No.

2007 08276

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roy Jack Franta</b>  |  | 2. Date of Death<br>Month Day Year<br><b>March 13, 2007</b>  |   | 3. Time of Death<br><b>23:20 M</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |   | 4c. County of Death<br><b>Harford</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>510-26-6435</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 14, 1927</b>   | 9. Birthplace (State or Foreign Country)<br><b>Kansas</b>   |
|   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |   | 10c. City, Town or Location<br><b>Havre de Grace</b>  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>108 Concove Way</b>   |   | 10f. Zip Code<br><b>21078</b>   |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Operations Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Trucking</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Michael (unk) Franta</b>  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary (unk) Dvork</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Monica Franta / Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 Concove Way, Havre de Grace, MD 21078</b>   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Erin Catholic Cem</b>   |   | 20c. Location - City or Town, State<br><b>Havre de Grace, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Stephen A. Hughes</b>   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.</b>  |   | 22. Address of Facility<br><b>1317 Cokesbury Road, Abingdon, MD 21009</b>   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>MALIGNANT LYMPHOMA</b> |  | 23b. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown                     |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)   |
|   | 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. Suresh Dhanjani</b>   |   |
| 29c. License number<br><b>245344</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>03/14/2007</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURESH DHANJANI, MD, 622 S. ORION AVE, HDG, MD 21078</b> |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |   |

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
3/13/07 2320  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08277

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND L. FISCHER SR.

2. Date of Death

Month Day Year  
March 9, 2007

3. Time of Death

6:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1811 Barrington Village Ct.

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

218-28-4833

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 31, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1811 Barrington Village Ct.

10f. Zip Code

21014

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5 +

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore

County Schools

17. Father's Name (First, Middle, Last)

Luther Fischer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kapinos

19a. Informant's Name/Relationship (Type, Print)

Raymond L. Fischer Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 Briarcliff Lane, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bayview Crematory

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

b. CHRONIC END-STAGE RENAL DISEASE

Due to (or as a consequence of):

c. CHRONIC HEART FAILURE

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

Approximate Interval Between Onset and Death

3 mth

2 mth

3 mth

2 year.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D12405

29d. Date signed (Month, Day, Year)

3/9/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES S. AWGELL, MD, 10755 Fall Rd, Baltimore, MD 21093

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08278

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard McKay Gore

2. Date of Death  
Month Day Year  
March 12, 20073. Time of Death  
5:40 PM

4a. Facility Name (If not institution, give street and number)

6809 Cherry Tree Court

4b. City, Town, or Location of Death

New Market

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

228-24-0291

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 14, 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

New Market

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6809 Cherry Tree Court

10f. Zip Code

21774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Vice President/Superintendent

16b. Kind of Business/Industry

Betco Block Company

17. Father's Name (First, Middle, Last)

Marshall Randolph Gore, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Eliza McKay

19a. Informant's Name/Relationship (Type, Print)

Ellanore Cramer Gore - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6809 Cherry Tree Ct., New Market, MD 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Nat. Memorial Park

Date

3/16/07

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Royston Funeral Home  
P.O. Box 163 Middleburg, VA 2011823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Prostate Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
13 YearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown3 ☐ Ectopic pregnancy23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D38509

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas Koutrelakos, M.D. 11065 Little Pautuxaent Prky., Columbia, MD 21044

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-1000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08279

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Albert Frank Gentile

2. Date of Death

March 12 2007

3. Time of Death

8:15 p

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Ctr.

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral Director

5. Social Security Number

214-14-0996

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3/31/1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2008 Longview Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Phillip Gentile

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Schoenhoff

19a. Informant's Name/Relationship (Type, Print)

Phyllis Jean Swezey (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2008 Longview Avenue Rosedale, Maryland 21237

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

3/16 2007

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

Michael C. Gaffney, Sr.

22. Name and Address of Facility

Bruzdinski Funeral Home PA  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endstage Renal Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Clostridium Difficile

Due to (or as a consequence of):

1 week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown

☐ Ectopic pregnancy  
☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D63830

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey B. Brown, M.D., 6701 N. Charles St. Room 4809, Towson, MD 21204

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State Registrar

Gentile, Albert  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23e or 28e-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 06280

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA

GILES

2. Date of Death

Month

Day

Year

3. Time of Death

MARCH

11

2007

7:30 A M

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

226-34-5716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

8. Date of Birth

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/17/1932

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 N. CENTRAL AVENUE, #405

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

3 YEARS

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

EVANGELIST

16b. Kind of Business/Industry

MINISTRY

17. Father's Name (First, Middle, Last)

FRANK CHAPPEL

18. Mother's Name (First, Middle, Maiden Surname)

PRISCILLA EVANS

19a. Informant's Name/Relationship (Type, Print)

TROY GILES / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

645 WESTMINSTER REACH, SMITHFIELD, VA

23430

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD VETERANS CEM.

Date

3/19/07

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HOWELL FUNERAL HOME 21207  
4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BOWEL Ischemia

Due to (or as a consequence of):

b. Amyloidosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 hours

3 months

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] K. Schlendorf, Medical Doctor

29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

MARCH 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kelly Schlendorf, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore MARYLAND 21287

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08281

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Teri Lee Gebhardt

2. Date of Death

Month Day Year  
March 7, 2007

3. Time of Death

18:00 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

180-44-5738

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 13, 1952

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2301 Franklin Chance Ct.

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Technologist

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Carl Franklin Morrow Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Arlene Mathiot

19a. Informant's Name/Relationship (Type, Print)

Fred C. Gebhardt / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2301 Franklin Chance Ct., Fallston, MD 21047

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Hilltop Service Corp 3-9-07

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Stephen W. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Melanoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Myocardial Infarction  
Sepsis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jason B. Birnbaum

29c. License number

D0056296

29d. Date signed (Month, Day, Year)

3/7/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason Birnbaum, M.D. 500 Upper Chesapeake Dr. Bel Air, MD 21047

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

K. H. H. H.

State  
Registrar

37107 / 1800  
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Gebhardt, Teri Lee M800258732  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 26 per verb. 8865-03/16/07dhb

Reg. No. 2007 08282

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Arweedia Gholston

Arweedia

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Arweedia N. Gholston</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>0914 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>420-48-2846</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>08 31 31</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Al</b>   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10e. Street and Number<br><b>6012 Baywood Ave</b>  |  | 10f. Zip Code<br><b>21209</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>5yrst</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  |
| 16b. Kind of Business/Industry<br><b>Baltimore City</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Golden Nettles</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Israel Knight</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Velvert Gholston-Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2509 Loyola Northway, Baltimore, Md 21215</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet.</b>   |  | 20c. Location - City or Town, State<br><b>3/6/07 Owings Mills, Md</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, Md 21215</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Asystole</b><br>Due to (or as a consequence of):<br>b. <b>MI (MYOCARDIAL INFARCTION)</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Cardiac Dysrhythmia</b>  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D46356</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 26, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Khosrow Tabassim 5601 Loch Raven Blvd, Baltimore, MD 21239</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08283

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles

2. Date of Death  
Month Day Year

March 15 2007

3. Time of Death

6:07A M

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-56-5257

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

54

8. Date of Birth

12-13-1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1X Yes 2 No

10e. Street and Number

504 N. Ellwood Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2X Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2X No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Pete's Cycle

17. Father's Name (First, Middle, Last)

Georgie Dewey Goodrich Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Janet Degrote

19a. Informant's Name/Relationship (Type, Print)

Belinda May Goodrich - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 N. Ellwood Avenue Baltimore, MD. 21205

20a. Method of Disposition

1 Burial 2X Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Crem.

Date

3-19-2007

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Joseph N. Zannino Jr. Funeral Home

22. Name and Address of Facility

263 S. Conkling St. Baltimore, Md. 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

4 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

3 Ectopic pregnancy

4 Pregnant at time of death

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Heart Failure

23e. Did tobacco use contribute to the cause of death?

1X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2X No

25. Was case referred to medical examiner?

1 Yes 2X No

26. Place of Death (Check only one)

Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1X Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Medical Doctor

29c. License number

R25-000

29d. Date signed (Month, Day, Year)

March 15 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Mulhearn M.D.

600 N. Wolfe Street Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

AMend #8 Per FH G865 3/19/07 JH

Certificate of Death

Reg. No.

2007 08284

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |                                |  |  |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPHINE GRAVES</b>   |  | 2. Date of Death<br>Month <b>03</b> Day <b>09</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>11 50 am</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>CHERRY LANE NURSING CENTER LAUREL</b>  |  | 4b. City, Town, or Location of Death<br><b>LAUREL</b>   |                                | 4c. County of Death<br><b>PG</b> Prince Georges  |  |
| 5. Social Security Number<br><b>579 34 7511</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month <b>1918</b> Day <b>29</b> Year <b>2007</b>   |
| Usual Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |                                |  |  |
| 10a. State<br><b>D.C.</b>   | 10b. County<br><b>Washington D.C.</b>                                      | 10c. City, Town or Location<br><b>Washington D.C.</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1400 Florida Ave NE Apt 711</b>  |  | 10f. Zip Code<br><b>20002</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |                                | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Cleaner</b>   |  |
| 16b. Kind of Business/Industry<br><b>Private</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Henry Elliott</b>   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nora Pulliman</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerome Graves, son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15034 Laurelland Pl. Laurel MD 20707</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>3/14/2007 Brentwood, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Tham z wall</b>   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home<br/>7601 Sandy Spring Rd Laurel MD 20707</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>b. GENERAL DEBILITY</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b><br><b>GENERAL DEBILITY</b><br><b>HYPERTENSION</b>   |  |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><b>Cygn M</b>  |  | 29c. License number<br><b>00045217</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>3/9/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ADEBOWALE ATAYIM 6201 GREENBELT RD College PK MD 20740</b>   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br><b>Tham z wall</b>   |                                |  |  |

State  
Registrar

Reg. No. 2007 08283

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03286

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VALERIE STUART GREEN

2. Date of Death

Month Day Year  
March 14, 2007

3. Time of Death

12:03A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

BRIGHTON GARDENS-ASSISTED LIVING

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

Funeral  
Director

5. Social Security Number

213-46-4846

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 2, 1925

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6451 North Charles Street, #311

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Residence

17. Father's Name (First, Middle, Last)

Harry Allen Stuart

18. Mother's Name (First, Middle, Maiden Surname)

Marie Dorothy Blandin

19a. Informant's Name/Relationship (Type, Print)

Valerie G. Spangler (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2317 Harcroft Road, Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem Grdns 3/17/2007 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Director (Type, Print)

Martin D. Lawson

22. Name and Address of Facility

MITCHELL-WIEDEFFELD FUNERAL HOME, INC.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bladder cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastrointestinal bleeding

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Assisted living Facility

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

March 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annon J. Charles MD 6701 N. Charles St Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Bren &amp; Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Amend #5 Per FH G865 3/27/07 JH  
 Certificate of Death  
 2007 08287  
 Reg. No.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>WALTER HEAGGANS</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>2007</b>   |   | 3. Time of Death<br><b>1:33A M</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General</b>  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   | 4c. County of Death<br><b>Howard</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>243-52-4022</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>6-25-1930</b> | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |
|   | Usual Residence of Decedent   |  |   |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>4345 Old Frederick Road</b>  |  | 10f. Zip Code<br><b>21229</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)                        |   |  |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |  | 16b. Kind of Business/Industry<br><b>Baltimore City</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charlie Heaggans</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Rankin</b>   |   |  |
|   | 19. Informant's Name/Relationship (Type, Print)<br><b>Thelma C. Heaggans (Wife)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4345 Old Frederick Rd., Baltimore, MD 21229</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |   |  |
| Physician<br>/Medical<br>Examiner             | 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>  |  | 22. Name and Address of Facility<br><b>Vaughn C. Greene Funeral Services<br/>5151 Baltimore Nat'l Pike, Balto., MD 21229</b>                        |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Atherosclerotic Cardiovascular Disease</b>  |  |   |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |
|   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 23d. Date of delivery<br>Month Day Year   |  |   |   |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |   |  |
|   | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |
|   | 29b. Signature and title of certifier<br><b>S. Olan</b>   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D 30641</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 14 2007</b>   |   |  |
|   | 30. Name and address of person who completed cause of death (Form 28a) (Type, Print)<br><b>Ramen Sabapathi 201-109 Back River Neck Road Baltimore Maryland 41221</b>  |  |   |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |   |  |

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08288

|   |   |   |   |  |  |  |  |   |
|---|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bette Jane Hemmeter</b>  |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>7:50 P M</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-20-8114</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 15, 1926</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Pasadena</b> |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>7808 Ducks Cove Road</b>   |   |   | 10f. Zip Code<br><b>21122</b>                  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>accountant</b>  |  |  | 16b. Kind of Business/Industry<br><b>financial</b>   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry Esposito</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Smith</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Hemmeter/spouse</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7808 Ducks Cove Road Pasadena, MD 21122</b>  |  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |  | 20c. Location - City or Town, State  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>  |  |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Chronic Obstructive Pulmonary Disease</b> |   |   |  |  |  |  | Approximate Interval Between Onset and Death                |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>George E. Wicks M.D.</b>  |   |   |   | 29c. License number<br><b>D41365</b>           |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George E. Wicks M.D. 301 Hospital Drive, Glen Burnie, MD 21061</b>   |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08289

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carlos Shawn Harris

2. Date of Death

Month Day Year

MARCH 08 2007

Day

Year

3. Time of Death

8:40 P M

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

216-72-2247

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 24, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1905 Beechwood Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

unk

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

Henry Frances Harris

18. Mother's Name (First, Middle, Maiden Surname)

Vernell Eleanor Gough

19a. Informant's Name/Relationship (Type, Print)

Vernell Harris/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1905 Beechwood Avenue Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. CLOSTRIDIUM DIFFICILE COLITIS

Due to (or as a consequence of):

c. END STAGE LIVER DISEASE

Due to (or as a consequence of):

d. END STAGE AIDS

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

DECUBITUS ULCER

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

MARCH 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANIA KASSEM GOODSAMARITAN 146 SPITAL 56.1 LOCHRAVEN BLVD, BALTIMORE, MD 21235

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 03290

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carlton Eugene Haulsee

2. Date of Death

Month Day Year  
March 15, 2007

3. Time of Death

7:00 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

7927 Oakwood Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

224-20-3896

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02/01/1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1549 Aldeney Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Arvel Henry Haulsee

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Mae Prater

19a. Informant's Name/Relationship (Type, Print)

Barbara Jean Raither (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7927 Oakwood Road, Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gard.

Date

03/19/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.  
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

acute myocardial infarction

b. Due to (or as a consequence of):

atherosclerotic cardiovascular disease

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughter's Residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Victoria Vavuk M.D.

29c. License number

D32381

29d. Date signed (Month, Day, Year)

March 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTORIA VAVUK M.D. 9106 Philadelphia Rd #304 Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond J. Halfter

2. Date of Death

March 12, 2007

3. Time of Death

8:08P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

308 Broadway Avenue

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

217-40-5933

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Dec. 5, 1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

308 Broadway Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Communications

16b. Kind of Business/Industry

Electronics

17. Father's Name (First, Middle, Last)

Carl Halfter

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Dudas

19a. Informant's Name/Relationship (Type, Print)

Mrs. Irene Halfter/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 Broadway Avenue Glen Burnie, Maryland 21061

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

March 16, 2007

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Selena Shive M01479

22. Name and Address of Facility

Singleton Funeral Home, P.A.  
1 Second Avenue Sw Glen Burnie, MD 2106123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic lung cancer

Approximate  
Interval Between  
Onset and Death

3 mos

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)  
☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mue m.d.

29c. License number

b54413

29d. Date signed (Month, Day, Year)

03/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Young J. Lee 3001 S. Hanover St. Baltimore MD 21225

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend #20B Per FH G865 3/16/07 JH  
Certificate of Death

Reg. No.

2007 08292

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert

Hamilton

2. Date of Death

March

Day

2007

Year

3. Time of Death

11:20 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

214-40-9847

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

8. Date of Birth

9-7-1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

md

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4102 Balfern Ave

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Brick Layer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

UKN

18. Mother's Name (First, Middle, Maiden Surname)

Marey E. Hamilton

19a. Informant's Name/Relationship (Type, Print)

Estelle Boston sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4102 Balfern Ave, Balto., Md. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Met Bayview Cemetery

Date

3/1/07

20c. Location - City or Town, State

Balto., Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Miller's Metropolitan Chapel  
1639 N. Broadway Balto., Md. 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. UREMIA

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 Days

5 Days

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] NAUDIA N. LAUDER, MONITORING ROS-000

29c. License number

29d. Date signed (Month, Day, Year)

MARCH 18, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAUDIA N. LAUDER, JOHN HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21260

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08293

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dewaine Curtis Hillenburg</b>   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>11:00 A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>12423 Eastern Avenue</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>220-13-0956</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 8, 1971</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  |  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |
| 10e. Street and Number<br><b>12423 Eastern Avenue</b>  |  |  |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>  |  | 16b. Kind of Business/Industry<br><b>Self-Employed Telephone Installation</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Norman T. Hillenburg, Jr.</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Weyant</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print) (father)<br><b>Norman T. Hillenburg, Jr.</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6924 University Drive, Baltimore, MD 21220</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem'l Gard</b>   |  | 20c. Date<br><b>3/17/2007</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes</b><br><b>9705 Belair Rd., Baltimore, MD 21236</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Self-inflicted Gun Shot wound To head</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |  |  |  |  |  |
| 23b. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year         |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>March 13, 2007</b>  |  | 28b. Time of Injury<br><b>1104 A M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred<br><b>Self-inflicted Gunshot wound To head</b>   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>CHase, Md 21230</b>   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>MD Deputy</b>  |  |  |  | 29c. License number<br><b>D18667</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 15, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip M. Lillo, MD 6 Trumble Hill Ct. Lutherville, Md 21093</b>  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |  |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, 12

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08294

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley S. Henschen

2. Date of Death

March 12, 2007

3. Time of Death

5:43 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10 Margate Road

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

5. Social Security Number

267-30-9770

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 17, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 Margate Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

- 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert E. Shock

18. Mother's Name (First, Middle, Maiden Surname)

Edna M. Gemmill

19a. Informant's Name/Relationship (Type, Print)

William R. Henschen Step-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

610 Jupiter Hills Court Arnold, Maryland 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

3-14-2007

20c. Location - City or Town, State

Towson Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RuckTowson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Militello, MD 6 Trimble Hill Ct. Lutherville, MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 16 2007

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08295

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD HARRY HART</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>2007</b>   |  |  |   | 3. Time of Death<br><b>5:55 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Roland Park Place</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |  |   | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>214-40-5803</b>   |  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F <input type="checkbox"/>   |  | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  |  | 8. Date of Birth<br>Month <b>January</b> Day <b>5</b> Year <b>1908</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent   |  |   |  |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |   | 10d. Inside City Limits<br><b>XX</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| 10e. Street and Number<br><b>830 West 40th Street</b>   |  |   |  | 10f. Zip Code<br><b>21211</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                            |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |  |  | 16b. Kind of Business/Industry<br><b>Public Library</b>                 |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Hart</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Murphy</b>   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Suzanne P O'Connell PR</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1802 Thornbury Road Baltimore, Maryland 21209</b>   |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GreenMount Crematory</b>   |  | Date<br><b>3/15/07</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Dennis A. Kenak</i>   |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home Inc<br/>6500 York Road Baltimore, Maryland 21212</b>   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Advanced arteriosclerotic cardiovascular disease</b>  |  |   |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>Years</b>   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |   |  |  |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |   |  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> COA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Isabelle MacGregor MD</i>   |  |   |  | 29c. License number<br><b>D13657</b>  |  |  |   | 29d. Date signed (Month, Day, Year)<br><b>March 14, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ISABELLE MacGREGOR, 830 W. 40th STREET, BALTIMORE, MD 21211</b>  |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 03296

Physician/  
Medical Examiner1. For State  
Registrar

1. Decedent's Name (First, Middle, Last)

KATHLEEN ANNE COYLE HICKS

2. Date of Death

Month Day Year  
March 12, 2007

3. Time of Death

2215 hrs

4a. Facility Name (if not institution, give street and number)

7515 Iroquois Road Avenue

4b. City, Town, or Location of Death

Sparrows Point

4c. County of Death

Baltimore County

5. Social Security Number

212-82-5025

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24Hrs

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Jan 19, 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Sparrows Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7515 Iroquois Avenue

10f. Zip Code

21219

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Psychotherapist

16b. Kind of Business/Industry

Mental Health

17. Father's Name (First, Middle, Last)

Richard Foley Coyle, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Agatha Sushinski

19a. Informant's Name/Relationship (Type, Print)

David A. Hicks (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7515 Iroquois Avenue, Sparrows Point, MD 21219

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

3/16/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

MITCHELL-WIEDEFELD FUNERAL HOME, INC.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause

(Cause or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

23e. Date of delivery

Month Day Year

23f. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23g. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

23h. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

23i. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

23j. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Mar. 12, 2007

28b. Time of Injury

Fnd 10:00 pm

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject inhaled helium

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) other scene

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7515 Iroquois Ave. Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08297

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lloyd Nathaniel James</b>  |   | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>6:39 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4192 Suitland Road #201</b>  |   | 4b. City, Town, or Location of Death<br><b>Suitland</b>  |   | 4c. County of Death<br><b>Prince Georges</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>225-76-9275</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1952</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince Georges</b>   |   | 10c. City, Town or Location<br><b>Suitland</b>   |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
|   | 10e. Street and Number<br><b>4192 Suitland Road #201</b>  |   | 10f. Zip Code<br><b>20746</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>10/74-10/79</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Environmental Supervisor</b>                         |   | 16b. Kind of Business/Industry<br><b>Veteran's Hospital</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edgar James</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Geraldine Cottman</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline James - Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4717 A Cardinal Court East Richmond, Va. 23228</b>               |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Shiloh Baptist Church Cemetery</b>  |   | Date<br><b>3/21/07</b>   |
| 20c. Location - City or Town, State<br><b>Williamsburg, Va.</b>   |   |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Robert B Baker</b>  |   | 22. Name and Address of Facility<br><b>Whiting's Funeral Home 7345 Pohick Road Trail Williamsburg, Va. 23185</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic gastric Cancer to Liver</b>  |   |  |   | Approximate Interval Between Onset and Death<br><b>5 months</b>  |
|   | 23b. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |   |  |
|   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) |   |  |   |  |
|   | 23d. Date of delivery<br>Month Day Year   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                       | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Jianqing Lin</b>  |   | 29c. License number<br><b>D0064525</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/16/07</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JIANQING LIN, MD 401 N. Broadway #1400 Baltimore, Md. 21231</b>  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08298

1- For  
State  
Registrar

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Lucille Edith Johnson</b>   |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>14</b> Year <b>07</b>   |  | 3. Time of Death<br><b>8:12 a.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Bosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>723 07 8905</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 12, 1922</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Essex</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>953 Martin Road</b>  |  | 10f. Zip Code<br><b>21221</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>5</b>  |  | 16a. Decedent's Usual Occupation (Specify kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Hill</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel C. Kelly</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lucinda Waterfield (daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>953 Martin Road Essex Maryland 21221</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory Inc</b>   |  | 20c. Date<br><b>3/15/2007</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home PA</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypoxia</b><br>Due to (or as a consequence of):<br><b>b. pulmonary edema</b><br>Due to (or as a consequence of):<br><b>c. fluid overload</b><br>Due to (or as a consequence of):<br><b>d. Renal failure</b> |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  |
| To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |  | 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diverticulitis, Atrial Fibrillation, COPD</b><br><b>Right thoracoplasty Secondary to childhood TB</b>   |  | 24d. Describe how injury occurred  |  | 24e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
|   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>BES 00000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Jessica Nunez 9000 Franklin Square Drive Baltimore, Md 21237</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br>  |  | 33. State Registrar   |  |

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08299

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORDELIA JOHNSON

2. Date of Death

Month Day Year  
MARCH 13 2007

3. Time of Death

9:50A M

4a. Facility Name (If not institution, give street and number)

CATONSVILLE COMMONS-GENESIS

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-22-7548

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/04/1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

16 FUSTING AVENUE

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

JARRITT SMITH

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA ANDERSON

19a. Informant's Name/Relationship (Type, Print)

HARRY B JOHNSON JR / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5301 OVERHILL ROAD, BALTIMORE, MD 21207

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALTIMORE NATIONAL

V.A. CEMETERY

Date

3/19/07

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME 21207

4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

check for heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. HTN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

7-10

7-10

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an

autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

☐ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Terakian, MD

29c. License number

D36942

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Terakian, MD 1009 Frederick Rd. Catonsville, MD 21228

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

B. Terakian

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 43

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08300

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Clyde Robert Kreppel

2. Date of Death

March 13, 2007

3. Time of Death

1:00 am

4a. Facility Name (If not institution, give street and number)

3815 Bayville Road

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

5. Social Security Number

215-30-5073

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/13/1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3815 Bayville Road

10f. Zip Code

21220

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No  
If Yes, Give Year or Dates: 1954  
1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Frederick Thomas Kreppel

18. Mother's Name (First, Middle, Maiden Surname)

Frances Bertha Sollers

19a. Informant's Name/Relationship (Type, Print)

Patsy Rue Kreppel (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3815 Bayville Road Middle River, Maryland 21220

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gard.

Date

3/16  
2007

20c. Location - City or Town, State

Middle River, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home PA  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD  
Respiratory pneumonia  
Seizure disorder

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. A. U. MD

29c. License number

041614

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan White 4920 Campbell White Woods, MD 21236

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 445

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1071

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08301

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Wayne

Kucz

2. Date of Death

Month Day Year  
March 14, 2007

3. Time of Death

11:45PM

4a. Facility Name (If not institution, give street and number)

1213 Delbert Avenue

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-54-4724

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 25, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1213 Delbert Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 years

College (1-4or 5+)

Self Employed

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Home Improvements

17. Father's Name (First, Middle, Last)

Bernard F. Kucz

18. Mother's Name (First, Middle, Maiden Surname)

Lillian V. Smith

19a. Informant's Name/Relationship (Type, Print)

Lillian V. Kucz

Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7523 Berkshire Road, Dundalk, MD. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

March 19, 2007

20c. Location - City or Town, State

Baltimore City, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.

7110 Sollers Point Road, Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
7 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hematologist /

Oncologist

29c. License number

D-51555

29d. Date signed (Month, Day, Year)

03-15-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SGIN AUNG, 9103 FRANKLIN SQUARE DRIVE #2200 BALTIMORE MD 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08302

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

James Harvey Kisner

2. Date of Death  
Month Day Year  
March 14, 20073. Time of Death  
0702 hrsFuneral  
Director

4a. Facility Name (if not institution, give street and number)

5 Slipstream Court

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore County

5. Social Security Number

215-46-8079

6 Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

11/13/1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Slipstream Court

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Worker

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Theodore Edwins Kisner

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Marshall Smith

19a. Informant's Name/Relationship (Type, Print)

Patricia Kisner (Personal Rep.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44 Transverse Avenue, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

03/16/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdzinski Funeral Home, P.A.  
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact shotgun Wound of chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Mar 14, 2007

28b. Time of Injury

FOUND: 0657 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) yard

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Slipstream Court, Middle River, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio MD.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

James B. Spauld

State Registrar

Baltimore, MD 21215-0036

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**Amend Item 1 per dr., 8885,05/28/07 RMB**  
**State of Maryland, Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **2007 08303**

**Physician  
/Medical  
Examiner**

**Baltimore, Maryland 21215-0020**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

**Division of Vital Records, P.O. Box 68760, 44**  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) <b>Robert Joseph Kipikas</b>  |  |  |  | 2. Date of Death<br>Month <b>Mar</b> - Day <b>11</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>10:00AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1351 S. Clinton Street</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death   |  |
| 5. Social Security Number<br><b>200-22-3415</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 12, 1930</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1351 S. Clinton Street</b>  |  | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>  |  | 16b. Kind of Business/Industry<br><b>Home Improvement</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>John Kipikas</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Sumame)<br><b>Helen Sumski</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Taylor Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>56 Brakeman Drive, Stewartstown, PA 17363</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>   |  | 20c. Date<br><b>3/14/07</b>  |  | 20d. Location - City or Town, State<br><b>Hampstead, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Stephen M Jenki</b>   |  |
| 22. Name and Address of Facility<br><b>Eline Funeral Home</b>  |  | 22b. Address<br><b>11824 Reisterstown Road</b>   |  | 22c. City or Town, State, Zip Code<br><b>Reisterstown, MD 21136</b>   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>END STAGE EMPHYSEMA</b><br>Due to (or as a consequence of):<br><br>b. <b>DEGENERATIVE JOINT DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Macular Degeneration</b>   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ben K. Jenki M.D.</b>   |  | 29c. License number<br><b>D20807</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ben K. Jenki M.D. 10 N. Greene St. 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08304

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lola A. Lewis</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>2007</b>  |  |  |  | 3. Time of Death<br><b>1:30 A M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Bradford Oaks Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |  |  |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| 5. Social Security Number<br><b>578 34 9375</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1928</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>                               |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Fort Washington</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>7814 Klovstad Drive</b>   |  |   |  | 10f. Zip Code<br><b>20744</b>  |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Aubrey Pillsbury</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude Owens</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ralph A. Lewis (Husband)</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7814 Klovstad Drive, Fort Washington, MD 20744</b> |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | Date<br><b>Mar 19, 2007</b>  |  | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>                               |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>MD0957</b>  |  |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arterio-venous aneurysm rupture</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>years</b> |  |   |  |  |  |  |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br><b>D19431</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Frank Ryan, M.D. 11701 Livingston Road, Fort Washington, MD</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08305

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine G. Lakis

2. Date of Death

March 10, 2007

3. Time of Death

10:00P M

4a. Facility Name (If not institution, give street and number)

2901 Boston St., Unit 402

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

219-32-2631

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-26-1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2901 Boston St., Unit 402

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Karageorge

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Karageorge

19a. Informant's Name/Relationship (Type, Print)

Michael Lakis - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2901 Boston St., Unit 402, Balto., MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Demetrios

Date

3-14-07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Bradley-Ashton Funeral Home,  
PA, 2134 Willow Spring Rd, 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Sept 2006

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] Dufahem, MD

29c. License number

DS3070

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Hopkins Hospital 1650 Orleans St Balto, MD 21231

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh 8865 3-16-07 vt

State of Maryland / Department of Health and Mental Hygiene

2007 08306

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

LEON

LEMON

2. Date of Death

Month Day Year

March 12 2007

3. Time of Death

18:42 PM

Funeral Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-44-3269

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

AUG. 20, 1946 MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3015 ROSALYN AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)

JANITOR

16b. Kind of Business/Industry

HOLIDAY INN

17. Father's Name (First, Middle, Last)

JAMES

LEMON

18. Mother's Name (First, Middle, Maiden Surname)

CORRINE JAMISON

19a. Informant's Name/Relationship (Type, Print)

ANNIE MITCHELL (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3015 ROSALYN AVE, BALTO, MD, 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST 03-20-07 OWINGS MILLS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Josephine E. Moore

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE, BALTO, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic coronary vascular disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MAHABIR S. ALI

29c. License number

MD.

00053377

29d. Date signed (Month, Day, Year)

March 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHABIR S. ALI, M.D. 2401 West Belvedere Ave., Baltimore, Maryland 21215

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Ann H. Spiller

ORIGINAL

Patient known as: Leon Lemon  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, E



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08307

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK JAMES LADD

2. Date of Death  
Month Day Year

March 12, 2007

3. Time of Death

6:55 P. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

278-46-4186

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

Feb. 14, 1926

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Worchester Road

10f. Zip Code

21286

10g. Citizen of What Country?

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Art History Professor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Albert Ladd

18. Mother's Name (First, Middle, Maiden Surname)

Grace Brush

19a. Informant's Name/Relationship (Type, Print)

David Lindenstruth (Per. Rep)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 Cedar Ave. Towson, Maryland 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

3-14-07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service/Licensee

Annis Stephen Kenackia

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LEUKEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

29c. License number

D43725

29d. Date signed (Month, Day, Year)

3/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Annis Stephen Kenackia

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

FREDERICK JAMES LADD  
Division of Vital Records, P.O. Box 68760,MARCH 12, 2007 6:55 p.m.  
Baltimore, Maryland 21215-0036

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Shantele Patrice Lynch

2. Date of Death  
Month Day Year  
March 8, 20073. Time of Death  
1304 hrs

4a. Facility Name (if not institution, give street and number)

1901 Sulphur Spring Road

4b. City, Town, or Location of Death

Lansdowne

4c. County of Death

Baltimore County

Funeral  
Director

5. Social Security Number

219-04-7779

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months

If Under 24Hrs.

Days

B. Date of Birth (MM/DD/YYYY)

MAY 28, 1969

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3705 Copley Rd

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

☒ Never Married ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

None

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DATA PROCESSOR

16b. Kind of Business/Industry

PUTTING IN FORMATS INTO COMPUTERS

17. Father's Name (First, Middle, Last)

Virgil Lynch

18. Mother's Name (First, Middle, Maiden Surname)

Elayne Davis

19a. Informant's Name/Relationship (Type, Print)

Virgil Lynch

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Copley Rd BALTO. MD 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial PK

Date

MAR 14, 2007

20c. Location - City or Town, State

Randallstown MD.

21. Signature of Funeral Service Licensee

Patricia Bitt

22. Name and Address of Facility

BETTS Funeral Home  
1129 N. CALDWELL ST. BALTO. MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No ☒ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy☐ Pregnant at time of death ☐ Other (Specify)☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ Other: ☐ Nursing Home ☐ Residence ☒ Other: Scene

27. Manner of Death

☐ Natural ☐ Pending Investigation☐ Accident ☐ Could not be determined☒ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Mar 8, 2007

28b. Time of Injury

FOUND: 1255 hrs

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) In a parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1901 Sulphur Spring Road, Lansdowne, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ling Li, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 9, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

Registrar's Signature

Ling Li

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08309

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Ellsworth H. Merson Jr

2. Date of Death

February 26, 2007

3. Time of Death

1540 hrs

4a. Facility Name (if not institution, give street and number)

1953 Sindee Drive

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-76-9417

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

Feb 20, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1953 Sindee Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

maintenance worker

16b. Kind of Business/Industry

refridgeration

17. Father's Name (First, Middle, Last)

Ellsworth H. Merson Sr

18. Mother's Name (First, Middle, Maiden Surname)

Irma Kerper

19a. Informant's Name/Relationship (Type, Print)

Sharon Pullen/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3012 California Avenue Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other Specify: in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wall, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?

1 ☒ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King, Jr., MD, Assistant Medical Examiner

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 27, 2007

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD, Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 16 2007

ORIGINAL

Baltimore, MD 21215-0036

Physician/  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08310

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Genevieve Inez Mohr

2. Date of Death  
Month Day Year  
March 13, 20073. Time of Death  
1:50 pm M

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-22-4118

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/10/1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Capri Drive

10f. Zip Code

21221

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner / Operator

16b. Kind of Business/Industry

Hair Salon

17. Father's Name (First, Middle, Last)

William Abrose Yeatman

18. Mother's Name (First, Middle, Maiden Surname)

Marian Alice LeBrun

19a. Informant's Name/Relationship (Type, Print)

Rich Gale (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12126 Buttonwood Lane Middle River, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

3/15  
2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael P. Hoff, Sr.

22. Name and Address of Facility

Bruzdzinski Funeral Home PA  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Renal Insufficiency

c. Due to (or as a consequence of):

Dementia

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

D. H. Smith MD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

3/14/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOALB A. HASHMI MD, 821 WENTAW ST Suite 308 BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

D. H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 418

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2007 08311**  
**Certificate of Death**

1- For State Registrar

Reg. No.

|   |  |  |  |   |  |  |   |  |
|---|--|--|--|---|--|--|---|--|
| Physician / Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Gerald Eugene Mundth</b>  |  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>10:10 P M</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Hart Heritage</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Street</b>  |  | 4c. County of Death<br><b>Harford</b>                                   |  |
| Funeral Director  | 5. Social Security Number<br><b>399-16-9672</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 14, 1927</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b>   |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Bel Air</b>                           |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>209 Duncannon Road</b>  |   | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:       |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Director of Plant Engineering Car &amp; Truck Manufacturer</b>   |   | 16b. Kind of Business/Industry   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Lyman Mundth</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vesta Mae Powell</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeff Mundth / Son</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Shelburne Road, Bel Air, MD 21015</b> |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Grdn</b>   |   | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.</b>  |   | 22. Address of Facility<br><b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>END STAGE DEMENTIA</b>  |  |  |   | Approximate Interval Between Onset and Death<br><b>~ 1 year</b>  |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Due to (or as a consequence of):</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |   |  |  |   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Facility</b> |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred<br><b>Facility</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                      |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  | 29c. License number<br><b>D 39889</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 12, 2007</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALFRED SPANUS 615 W MACPHAIL BEL AIR MD 21014</b>  |  |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lou Miller

2. Date of Death

March 13, 2007

3. Time of Death

8:50 P M

4a. Facility Name (If not institution, give street and number)

2852 Beckon Drive

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

5. Social Security Number

214-36-9347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 17, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2852 Beckon Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

VA Medical Center

17. Father's Name (First, Middle, Last)

Lloyd A. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Anna Louise Norton

19a. Informant's Name/Relationship (Type, Print)

Samuel Miller Sr./ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2852 Beckon Drive, Edgewood, MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

John Wesley U.M. Cem. 3-19-07

Date

20c. Location - City or Town, State

Abingdon, Maryland

21. Signature of Funeral Service Licensee

Steph A. Neigh

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause in each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
6 YEARS

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

John P. Edwards, MD

29c. License number

D 31775

29d. Date signed (Month, Day, Year)

MARCH 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John P. Edwards, MD

2112 BELAIR ROAD

HANSTON, MARYLAND

21047

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Bryan H. Smith

State

Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08313

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |                                |  |   |
|---|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>William T. McNamara, Jr.</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>12</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>2:25 AM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Nursing Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death<br><b>N/C</b>  |   |
| 5. Social Security Number<br><b>216-05-7690</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1917</b>                                      |   |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |                                |  |   |
| Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Nottingham</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>12 Delgreen Court</b>  |  |   |  | 10f. Zip Code<br><b>21236</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Inspector</b>  |                                | 16b. Kind of Business/Industry<br><b>Baltimore City</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>William T. McNamara, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Pearl Eades</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Clifton M. Gonce (step-son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4305 Four Mill Road, Nottingham, MD 21236</b>  |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>3/17/2007</b>   |                                | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>                              |   |
| 21. Signature of Funeral Service Licensee<br><b>Brian D. Jones</b>  |  |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes<br/>9705 Belair Rd., Baltimore, MD 21236</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>END STAGE ISCHEMIC CARDIOMYOPATHY</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  | Approximate Interval Between Onset and Death  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |                                |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b>  |  |   |  |  |                                |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><b>Wofon Anueh, MD</b>   |  |   |  | 29c. License number<br><b>D0061789</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH, 12, 2007</b>                                  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LORRAINE OFORI-ANUEH, 9106 PHILADELPHIA RD, STE 208, BALTIMORE, MD 21237</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |                                |  |   |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08314

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leroy Marine Narango

2. Date of Death

Month Day Year  
MARCH 15 2007

3. Time of Death

5:10<sup>AM</sup>

4a. Facility Name (If not institution, give street and number)

LORIE @ RIVERSIDE

4b. City, Town, or Location of Death

BEL CAMP

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

219-07-2308

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 4, 1921

9. Birthplace (State or Foreign

Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Cedar Spring Road

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Tool and Die Maker

16b. Kind of Business/Industry

Metal Packaging

17. Father's Name (First, Middle, Last)

David William Narango

18. Mother's Name (First, Middle, Maiden Sumame)

Marie Ament

19a. Informant's Name/Relationship (Type, Print)

Paula Narango (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 Cedar Spring Road Bel Air, Maryland 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bayview Crematory

Date

03/16/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd. Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Chronic Obstructive Pulmonary Disease

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D27975

29d. Date signed (Month, Day, Year)

3/15/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID McCLINE JR 615 MacPhail Rd Bel Air, MD 21014

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08315

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy

Jane

Oechsler

2. Date of Death

Month

Day

Year

March 15, 2007

3. Time of Death

1:30 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Woods Nursing Home

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

214-30-3741

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
September 7, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8006 Wallace Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7 years

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Henry Yeager

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn A. Gibson

19a. Informant's Name/Relationship (Type, Print)

Elmer Oechsler Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8006 Wallace Road, Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory, or other place)

Gardens of Faith Cemetery

Date

March 19, 2007

20c. Location - City or Town, State

Rosedale, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure - Acidosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to the  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Severe COPD

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40008

29d. Date signed (Month, Day, Year)

3/16/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jim Parshall 9105 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08316

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE

MARIE

O'NEIL

2. Date of Death

Month  
MARCHDay  
14,Year  
2007

3. Time of Death

1:10 P.M.

4a. Facility Name (If not institution, give street and number)

FOREST HILL HEALTH &amp; REHAB CENTER

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

216-18-3205

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 24, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

555 South Atwood Rd. Apt. 408

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Thomas (unk) Lamendola

18. Mother's Name (First, Middle, Maiden Surname)

Mary Grace Sortino

19a. Informant's Name/Relationship (Type, Print)

Charles T. O'Neil / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 Lelia Ct., Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

3-16-07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McComas Funeral Home, P. A.

50 W. Broadway, Bel Air, Maryland 21015

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Approximate  
Interval Between  
Onset and Death

3 weeks

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H41069

29d. Date signed (Month, Day, Year)

March 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STANLEY KMAN - 1308 BUSINESS CENTER WAY, SUITE 102 - EDGEWOOD, MD. 21040

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08317

1- For State Registrar

Physician/  
Medical Examiner

Funeral  
Director

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jonathan Pierre</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>10</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>1734 hrs</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Route 32 and Samford Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Ft. Meade</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>593 93 4398</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>21</b> Yrs.  |  |
| 8. Date of Birth (MM/DD/YYYY)<br><b>Sept 4, 1985</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |   |  |
| Usual Residence of Decedent   |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Fort Meade</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 10e. Street and Number<br><b>7226 G. Hall Street</b>  |  | 10f. Zip Code<br><b>20755</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Active Duty</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:   |  |
| 14. Race - American Indian, Black, White, etc.<br><b>African American</b>   |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>A.I.C.</b>   |  | 16b. Kind of Business/Industry<br><b>US Air Force</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph B. Pierre</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Woolley</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Woolley (mother)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1056 Northwest 13 Street, Pembroke Pines, FL 33026</b>   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Vista Memorial Gardens</b><br><del>Calvary Chapel Plantation</del>  |  | 20c. Location - City or Town, State<br><b>Miami Lakes</b><br><del>Plantation, Florida</del>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED <b>20b,c per fh g866 4-3-07 vt</b> |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>g <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Mar 10, 2007</b>  |  | 28b. Time of Injury<br><b>1728 hrs</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Operator of motorcycle which struck guardrail</b>  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Major Road / Highway</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Route 32 and Samford Road, Ft. Meade, MD</b>  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 11, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Mary G. Ripple MD, Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, MD 21215-0036

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State Registrar

07-01543  
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Items 5, 10a, b, c, e, f, per ME 8869, 07/05/07dhh

2007 08318

1- For State Registrar

Reg No.

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| Physician/<br>Medical Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Leonard Prahl</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>24</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>1700 hrs</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Stream near Rt 175 &amp; Blobs Park Rd</b>   |  | 4b. City, Town, or Location of Death<br><b>Jessup</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-48-9796</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs. | 8. Date of Birth (MM/DD/YYYY)<br><b>Apr 12, 1959</b>  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Usual Residence of Decedent<br>10a. State <b>PA</b> 10b. County <b>Wayne</b> 10c. City, Town or Location <b>Lakeville</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>HCI Box 51</b><br><b>7959 Telegraph Road</b>   |  | 10f. Zip Code<br><b>19438</b><br><b>21144</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Drigin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: <b>white</b> |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unk</b>   |  | 16b. Kind of Business/Industry<br><b>unk</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>unk</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Abbott</b>  |  |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print )<br><b>Diane Shulski/sister</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7959 Telegraph Road Severn, MD 21144</b>  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify: <b>in state</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>West Arundel Crematory</b>   |  | 20c. Location - City or Town, State<br><b>4/6/2007 Odenton, MD</b>  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>Rendon Bailey F.H., P.A. 2818 E. Baltimore</b><br><b>Baltimore, MD 21201 21224 St.</b>   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Undetermined Asphyxia</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>23a, 27, 28d, per ME 8887 1/15/09 TT</b><br><b>#20a-c, 22, per FH, 23a, 27, 28a-f, per ME, 8867, 5/8/07 TT</b> |  | Approximate Interval Between Onset and Death<br><b>✓</b>  |  |   |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month <b>1</b> Day <b>1</b> Year <b>2007</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>23a, 27, 28d, per ME 8887 1/15/09 TT</b><br><b>#20a-c, 22, per FH, 23a, 27, 28a-f, per ME, 8867, 5/8/07 TT</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene           |  |   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Fnd 2/24/2007</b> 28b. Time of Injury<br><b>Fnd 4:50 pm</b> 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>unk</b>  |  | 28d. Describe how injury occurred<br><b>unk Subject was assaulted</b>   |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt 175 @ Blobs Park Road Jessup, MD</b>  |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt 175 @ Blobs Park Road Jessup, MD</b>  |  |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Pamela E. Southall, MD</b>  |  |   |
|   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 25, 2007</b>   |  |   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  | 33. Registrar's Title<br><b>[Signature]</b>   |  |   |

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08319

1- For State  
RegistrarPhysician/  
Medical ExaminerFuneral  
Director

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ira Franklin Parsons</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>1200 hrs</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>11277 Snethen Church Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Mardela Springs</b>   |  | 4c. County of Death<br><b>Wicomico</b>   |   |
| 5. Social Security Number<br><b>214-66-8879</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   | 8. Date of Birth (MM/DD/YYYY)<br><b>Jan 19, 1958</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |  |  |  |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Wicomico</b>   | 10c. City, Town or Location<br><b>Mardela Springs</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>11277 Snethen Church Road</b>  |  | 10f. Zip Code<br><b>21837</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>disabled</b>   |  | 16b. Kind of Business/Industry<br><b>none</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>George Billy Parsons</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Jean Laird</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna Parsons/former spouse</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11277 Snethen Church Road Mardela Springs, MD 21837</b>  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | 20c. Location - City or Town, State  |   |
| 21. Signature of Funeral Service Licensee<br><i>Ronald S. Wade, Director</i>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Oxycodone intoxication</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>#23a, 27, 28a-f, per ME, g865, 3/28/07 TT</b> |  |  |  |  | Approximate Interval Between Onset and Death                |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other Scene  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>End 3/11/2007</b>   | 28b. Time of Injury<br><b>End 11:09 am</b>           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>unk</b>             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>House</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>11277 Snethen Church Rd.<br/>Mardela Springs, MD</b>  |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Amend #4c Per

PHY C865 3/20/07-JH

Certificate of Death

Reg. No.

2007 08320

John Pennington  
Baltimore, Maryland 21215-0036

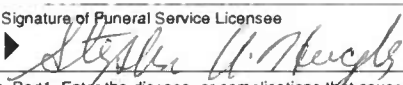
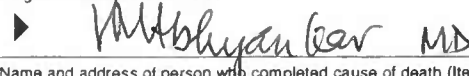
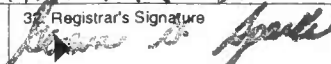
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Wallace Pennington</b>   |  | 2. Date of Death<br>Month Day Year<br><b>March 14, 2007</b>   |   | 3. Time of Death<br><b>6:15 A M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>299 Wakely Terrace</b>  |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>  |   | 4c. County of Death<br><b>21014 Harford</b>  |   |
| 5. Social Security Number<br><b>220-18-6276</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 30, 1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent  |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Bel Air</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>299 Wakely Terrace</b>  |  | 10f. Zip Code<br><b>21014</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Truck Driver</b>  |   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business/Industry<br><b>Transport</b>  |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Bradley Pennington</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Emily Littlewood</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ann Sellers / Niece</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>299 Wakely Terrace, Bel Air, Maryland 21014</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gdn</b>   |   | 20c. Location - City or Town, State<br><b>3-17-07 Bel Air, Maryland</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P. A.<br/>50 W. Broadway, Bel Air, Maryland 21014</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>DIABETES MELLITUS</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)         |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |
| 29b. Signature and title of certifier<br> <b>MD</b>   |  | 29c. License number<br><b>D25027</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 14 2007</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VIJAY M. ABHYANKAR 2 NORTH AVE BEL AIR MD 21014</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br>  |   |  |   |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08321

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

LUCILLE PREDDY

2. Date of Death

03 14 2007

3. Time of Death

2:40a M

4a. Facility Name (If not institution, give street and number)

Summit Park Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

212-22-2218

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

94

8. Date of Birth (Month, Day, Year)

11 01 12

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1502 Frederick Road

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Care Nurses Aide

16b. Kind of Business/Industry

Care Provider

17. Father's Name (First, Middle, Last)

Alex Cook

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Lewis

19a. Informant's Name/Relationship (Type. Print)

Erika Predy-Daughter-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3521 Wild Cherry Road, Baltimore, Md 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge

Date

3/17/07

20c. Location - City or Town, State

Pikesville, Md

21. Signature of Funeral Service Licensee

Sala March

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Dr. Anthony PHYSICIAN

29c. License number

D42723

29d. Date signed (Month, Day, Year)

MARCH 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERA HALLI M HARISH

5310 OLD COURT ROAD RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08322

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Winfield Scott Payne

2. Date of Death

Month Day Year  
March 15, 2007

3. Time of Death

10:40 A M

4a. Facility Name (If not institution, give street and number)

Oak Crest Care Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

524-05-0459

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 20, 1917

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State 10b. County  
Maryland Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd., Unit #1304

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Research Analyst

16b. Kind of Business/Industry

Defense Department

17. Father's Name (First, Middle, Last)

Winfield Scott Payne, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Hulse

19a. Informant's Name/Relationship (Type, Print)

Barbara R. Payne (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8820 Walther Blvd., Unit #1304, Parkville, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

3/19/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral/Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage dementia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Month

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D53115

29d. Date signed (Month, Day, Year)

March 15th 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff Anderson 8800 Walther Blvd Parkville MD 21234

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitW. SCOTT PAYNE  
Division or Vital Records, P.O. Box 68760,

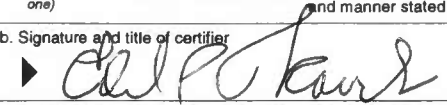

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08323

|   |   |                                 |   |   |   |  |  |  |   |  |  |
|---|---|---------------------------------|---|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JULIANNA PODSIADLO</b>                       |                                 |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>March 14 2007</b> |  | 3. Time of Death<br><b>8:30 AM</b>                        |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1220 Tugwell Drive</b> |                                 |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b> |  | 4c. County of Death<br><b>Baltimore</b>                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-60-0058</b>   |                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>12/17/1907</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Poland</b> |  |  |
|   | Usual Residence of Decedent   |                                 |   |   |   |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Catonsville</b>   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>1220 Tugwell Drive</b>   |   |                                 |   | 10f. Zip Code<br><b>21228</b>   |   | 10g. Citizen of What Country?<br><b>Poland</b>   |  |  |   |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Religious Sister</b>  |   |  | 16b. Kind of Business/Industry<br><b>Healthcare</b>        |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Podsiadlo</b>   |   |                                 |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine Unknown</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sr. Krystyna Mroczek - Friend</b>  |   |                                 |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1220 Tugwell Drive Catonsville, Maryland 21228</b> |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Rosary Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>03/17/07 Baltimore, Maryland</b>   |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                                 |   | 22. Name and Address of Facility<br><b>David J. Weber Funeral Homes P.A.<br/>401 S. Chester Street Baltimore, Maryland 21231</b>  |   |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Atherosclerotic Cardiovascular Disease</b><br><b>Myocardial heart failure</b> |   |                                 |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2 weeks</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic Cardiovascular Disease</b><br><b>Myocardial heart failure</b>  |   |                                 |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                 |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                                 |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                                 |   | 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br><b>D34951</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 15th 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Edmund P. O'Leary 405 E. 1st St. Baltimore MD 21202</b>  |   |                                 |   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   |                                 |   | 32. Registrar's Signature<br>  |   |  |  |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08324

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |                                |  |  |
|---|--|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN JOSEPH PREISINGER</b>   |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>14</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>10:30AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>TIMONIUM</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>219-18-8174</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>6-25-1925</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |  |                                |  |  |
| Usual Residence of Decedent   |  |  |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>ROSEDALE</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>8122 WOODHAVEN ROAD</b>  |  |  |  | 10f. Zip Code<br><b>21237</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-45</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER</b>  |                                | 16b. Kind of Business/Industry<br><b>OFFICE MACHINES</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN PREISINGER</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LEAH (KING)</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EVELYN PREISINGER/WIFE</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8122 WOODHAVEN ROAD ROSEDALE, MD 21237</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>   |  | Date<br><b>3-16-2007</b>   |                                | 20c. Location - City or Town, State<br><b>PARKVILLE, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>CVACH/ROSEDALE FUNERAL HOME</b><br><b>1211 CHESACO AVE ROSEDALE, MD 21237</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                |  |  |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D43725</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3/14/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |  |  |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |  |  | 32. Registrar's Signature<br>  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

MARCH 14, 2007 10:26 a.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

JOHN PREISINGER

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

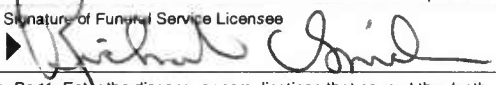

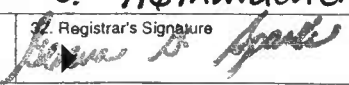
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08325

1- For  
State  
Registrar

|   |   |   |   |  |  |  |                                  |  |
|---|---|---|---|--|--|--|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary C. Phillips                        |   |   |  | 2. Date of Death<br>Month Day Year<br>March 14, 2007 |  | 3. Time of Death<br>9:35 A M     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1207 North Avenue |   |   |  | 4b. City, Town, or Location of Death<br>Baltimore    |  | 4c. County of Death<br>Baltimore |  |
| Funeral<br>Director   | 5. Social Security Number<br>278-24-9014  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>99 Yrs. | 8. Date of Birth (Month, Day, Year)<br>April 25, 1907  |  | 9. Birthplace (State or Foreign Country)<br>Ohio   |                                  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |                                  |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Baltimore   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                  |  |
| 10e. Street and Number<br>1207 North Avenue   |   |   |   | 10f. Zip Code<br>21227   |  | 10g. Citizen of What Country?<br>USA   |                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  | 16b. Kind of Business/Industry<br>Own Home   |                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Nelson Barnes Pittenger  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minnie Malone Moore   |  |  |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Nina Mae Phillips / Daughter  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1207 North Avenue, Baltimore, Maryland 21227  |  |  |                                  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Mem. Pk.  |   | 20c. Location - City or Town, State<br>Elkridge, Maryland  |  | 20d. Date<br>3/17/2007   |                                  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br>Hubbard Funeral Home, Inc.<br>4107 Wilkens Avenue, Baltimore, Maryland 21229   |  |  |                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute urosepsis<br>Due to (or as a consequence of):<br>b. Chronic renal failure<br>Due to (or as a consequence of):<br>c. Acute renal failure<br>Due to (or as a consequence of):<br>d. Hyperkalemia |   |   |   |  |  |  |                                  |  |
| Approximate Interval Between Onset and Death<br>7 days<br>5 years<br>5 days<br>5 days   |   |   |   |  |  |  |                                  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |  |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension<br>Paroxysmal Atrial Fibrillation  |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                  |  |
| 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   |  |  |  |                                  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br>D 19558   |  | 29d. Date signed (Month, Day, Year)<br>03-15-2007  |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Glen E Johnson MD, 716 Maidenchoice Lane suite 205, Baltimore, Maryland 21028   |   |   |   |  |  |  |                                  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 16 2007  |   |   |   | 32. Registrar's Signature<br>   |  |  |                                  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08326

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

THELMA

PAGE

2. Date of Death

March 13, 2007

3. Time of Death

2:50 p M

4a. Facility Name (If not institution, give street and number)

6605 8th Place

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

577-42-4584

6. Sex

1 M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 25, 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6605 8th Place

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
6yrs.16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Music Education Teacher

16b. Kind of Business/Industry

DC Public Schools

17. Father's Name (First, Middle, Last)

Gilbert Pegram

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Lee

19a. Informant's Name/Relationship (Type, Print)

Arleta Cunningham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2105 Banning Pl  
Hyattsville, MD. 20783-2848

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 3-16-2007

Date

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.  
4217 9th St. N.W. Washington, D.C. 2001123a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Breast Carcinoma

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Richard M. H. M.P.

29c. License number

MD 11903 DC

29d. Date signed (Month, Day, Year)

3/15/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard Wilson, MD 106 Irving St. N.W. Washington, DC 20010

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Bernard Wilson

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08327

1- For  
State  
Registrar

|  |   |  |   |  |   |                          |   |   |   |  |   |  |
|--|---|--|---|--|---|--------------------------|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Annie Powell</b>   |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>12</b> Year <b>2007</b>  |                          |   |   | 3. Time of Death<br><b>6:18 P M</b>                                     |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secours Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                          |   |   | 4c. County of Death<br><b>N/A</b>                                       |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-26-0269</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |                          | 8. Date of Birth<br>Month, Day, Year<br><b>May 28, 1923</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>             |  |   |  |
|  | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Maryland</b>   |                          |   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>                       |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>2831 Guym Falls Parkway</b>  |                          |   |   | 10f. Zip Code<br><b>21246</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                           |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                          |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>   |                          |   |   | 16b. Kind of Business/Industry<br><b>Baltimore City Public Schools</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Sidney Peters</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lelia Oneil</b>   |                          |   |   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vanessa Powell Cooper - daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8905 Greens Lane Randallstown, Maryland</b>   |                          |   |   |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |                          |   |   | Date<br><b>3/19/07</b>  |  | 20c. Location - City or Town, State<br><b>Brooklyn Park, Maryland</b> |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Kevin Parker</b>  |  |   |  | 22. Name and Address of Facility<br><b>Parker Funeral Home, P.A. 21229<br/>3512 Frederick Ave. Baltimore, Maryland</b>  |                          |   |   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Massive Bilateral Pulmonary Emboli</b> |  |   |  |   |                          |   |   | Approximate Interval Between Onset and Death<br><b>48 hours</b>         |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Massive Bilateral Pulmonary Emboli</b>   |  |   |  |   |                          |   |   |   |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |                          |   |   | 23d. Date of delivery<br>Month Day Year                                 |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatic Induced Thrombocytopenia<br/>Acute Blood Loss Anemia.<br/>Atrial Fibrillation</b>   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                          |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred                        |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                          |   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Coroner/Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br><b>H. Neal Reynolds</b>   |   |                          |   | 29c. License number<br><b>D 27163</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>03-14-2007</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Neal Reynolds MD, Bon Secours Hospital of Baltimore</b>  |   |  |   | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |   |                          |   | 32. Registrar's Signature<br><b>Kevin Parker</b>  |   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08328

|   |   |  |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARY ANN PROVENZA</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>2007</b>   |  |   |  | 3. Time of Death<br><b>11:23A</b> M  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>307 E Coldspring Lane</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>433-16-9214</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 19, 1915</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Louisiana</b>                         |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>                                      |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>307 E Coldspring Lane</b>  |  |   |  | 10f. Zip Code<br><b>21212</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookkeeper</b>  |  | 16b. Kind of Business/Industry<br><b>Pharmacy</b>                       |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Fulco</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Fava</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Theresa Summers Niece</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>307 E Coldspring Lane Baltimore, Maryland 21212</b>   |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cem</b>  |  | Date<br><b>3/17/07</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                    |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Dennis Stephen Youakim</i>  |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home Inc.<br/>6500 York Road Baltimore, Maryland 21212</b>  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Septic Shock</b>  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>24h</b>              |  |  |  |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)<br><b>Urosepsis</b>   |  |   |  |   |  | <b>24h</b>  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>UTI</b>  |  |   |  |   |  | <b>days</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year                                 |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Advanced Dementia</b><br><b>ASCVD</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29b. Signature and title of certifier<br><i>F. Belgado MD</i>   |  | 29c. License number<br><b>D32717</b>                                    |  | 29d. Date signed (Month, Day, Year)<br><b>March 15, 2007</b>                         |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Fernando A Belgado MD 6701 North Charles Street Suite 4202 Towson MD 21204</b>   |  |   |  |   |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2007 08329

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVIA H PASSEN

2. Date of Death

03 14 2007 04:49 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

212-36-5115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

8. Date of Birth

06/16/1937

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

FL

10b. County

BROWARD

10c. City, Town or Location

FORT LAUDERDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3055 HARBOR DRIVE #902

10f. Zip Code

33316

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

NATHAN

18. Mother's Name (First, Middle, Maiden Surname)

HENDLER

FLORENCE

TRUSS

19a. Informant's Name/Relationship (Type, Print)

SELVIN PASSEN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3055 HARBOR DRIVE #902-FT. LAUDERDALE, FL. 33316

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAR SINAI CONG.

Date

03/15/2007

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

MCH 12

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Autoimmune Hemolytic Anemia

Due to (or as a consequence of):

b. Myocardial Infarction/Coronary Artery

Due to (or as a consequence of):

c. Myelodysplastic Syndrome

Due to (or as a consequence of):

d. Acidosis

Approximate Interval Between Onset and Death

2 weeks

minutes

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Auerbach

29c. License number

D33551

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. AUERBACH, 9110 Philadelphia Rd #714, Baltimore 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

M. Auerbach

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.PASSEN SYLVIA  
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08330

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Mary Dorothy Reinhardt

2. Date of Death

Month Day Year  
March 2, 2007

3. Time of Death

0715 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

unk

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs

If Under 1 Year

Months Days Hours Min.

If Under 24Hrs.

8. Date of Birth (MM/DD/YYYY)

Jan 7, 1952

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15635 Deer Lodge Circle

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

unk  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) unk  
College (1-4 or 5+) unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other Specify: in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Mar 2, 2007

28b. Time of Injury

0642 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Pedestrian struck by auto

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Route 40 at Deer Lodge Drive, Hagerstown, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

Zabiullah Ali

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 3, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Ronald S. Wade

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08331

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY FRANCES ROBINSON

2. Date of Death

Month Day Year  
MARCH 12 2007

3. Time of Death

7:15A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3616 W. BELVEDERE AVENUE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

215-30-4018

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06/07/1935

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3616 W. BELVEDERE AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

DIRECT CARE AIDE (GNA)

16b. Kind of Business/Industry

BALTIMORE CITY  
HOSPITAL

17. Father's Name (First, Middle, Last)

ALPHONSO BROWN

18. Mother's Name (First, Middle, Maiden Surname)

LEONA BROWN

19a. Informant's Name/Relationship (Type, Print)

SANDY JACKSON JR / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3609 HAYWARD AVENUE, BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEM. PARK

Date

3/20/07

20c. Location - City or Town, State

WINDSOR MILL, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howell Funeral Home 21207  
4600 Liberty Heights Ave, Baltimore, MD

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Congestive Heart Failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Ten years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

037928

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Kenneth Ruby 2435 West Belvedere Ave Baltimore MD 21215

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #5, per FH, 8865, 3/23/07 TT  
State Registrar

## Certificate of Death

Reg. No.

2007 08332

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joan G. Rush</b>  |   | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>4:10 P M</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2214 Old Eastern Avenue</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>0763<br/>214-40-8762</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>7-26-1941</b>                      | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   |  |
|   | Usual Residence of Decedent  |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|   | 10e. Street and Number<br><b>2214 Old Eastern Avenue</b>   |   | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |   |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Consultant</b>              |  | 16b. Kind of Business/Industry<br><b>Sales</b>   |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>John Raab</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Zubalik</b>  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Rush - Son</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6802 Linden Ave., Baltimore, MD 21206</b>     |  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>  |  | 20c. Location - City or Town, State<br><b>3-17-07 Baltimore, MD</b>  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Bradley-Ashton Funeral Home PA, 2134 Willow Spring Rd, 21222</b>   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>2 years</b> |   | Approximate Interval Between Onset and Death<br><b>2 years</b>  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year                                      |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D30929</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/14/2007</b>                      |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Celano, 6565 N. Charles ST BALTIMORE MD 21204</b>   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  | 32. Registrar's Signature<br>   |   |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21260-0760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08333

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Earl Reed

2. Date of Death  
Month Day Year

March 16, 2007

3. Time of Death  
7:27 AM M

4a. Facility Name (If not institution, give street and number)

2205 Old Joppa Rd.

4b. City, Town, or Location of Death

Joppa

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212-36-8534

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)

06/24/1941

9. Birthplace (State or Foreign  
Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2205 Old Joppa Rd.

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintenance Coordinator

16b. Kind of Business/Industry

Continental Can  
Company

17. Father's Name (First, Middle, Last)

Rodney James Reed

18. Mother's Name (First, Middle, Maiden Surname)

Ocie Ann Morgan

19a. Informant's Name/Relationship (Type, Print)

David Reed/Self

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2205 Old Joppa Rd. Joppa, MD 21085

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

3-17-07

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

[Signature] msl358

22. Name and Address of Facility

Cremation and Funeral Alternatives

8717 Green Pastures Drive Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):b. Squamous cell carcinoma of lung  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 days

6 months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gangrene of foot due to peripheral  
artery disease. Coronary insufficiency

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D20685

29d. Date signed (Month, Day, Year)

3-16-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl S. Friedman, MD, 515 Fairmount Ave, Towson MD 21286

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08334

1- For  
State  
Registrar

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOEL RIOS</b>  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 14 2007</b>   |  | 3. Time of Death<br>1:30P M  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5005 EAST HOFFMAN STREET</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>n/a</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>467-82-1511</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>11-4-1950</b>                                | 9. Birthplace (State or Foreign Country)<br><b>TEXAS</b>   |
|  | Usual Residence of Decedent   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>5005 EAST HOFFMAN STREET</b>   |  | 10f. Zip Code<br><b>21205</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>VIETNAM</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>1</b>                                 |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAINTENANCE</b>   |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN (UNKNOWN)</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSEMARI RIOS/WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5005 EAST HOFFMAN STREET BALTIMORE, MD 21205</b>                 |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>   |  | 20c. Location - City or Town, State<br><b>3-15-07 CATONSVILLE, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237</b>   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>b. <b>DIABETES MELLITUS - TYPE II</b><br>Due to (or as a consequence of):<br>c. <b>14 PERCIBOWDREMIA</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>10/02</b><br><b>11/02</b> |  |  |  |  |
| IF FEMALE: <b>N/A</b><br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALCOHOLISM</b>  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br><b>Soltail Mustafa, MD</b>  |   | 29c. License number<br><b>D-48025</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-14-07</b>                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Soltail M. PARAI, MD, 1224 CHESACO AVE, 21237</b>   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |   | 32. Registrar's Signature<br>  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08335

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PAUL HENRY ROBINSON SR.

2. Date of Death

03 09 2007

3. Time of Death

0448 M

4a. Facility Name (If not Institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-26-8302

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

68 Yrs.

8. Date of Birth (Month, Day, Year)

1/22/39

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

708 Dorchester Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2X Married  
3 Widowed 4 Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 Yes 2X No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: African-American

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Henderson Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Robinson

19a. Informant's Name/Relationship (Type, Print)

Mary Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Dorchester Rd., Balto. MD 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Louden Park Cem.

Date

3/17/07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wylie F/H P.A. of Balto. Co.  
9200 Liberty Rd., Randallstown, MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. SEPTIC SHOCK  
Due to (or as a consequence of):b. NECROTIZING FASCIITIS  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an  
autopsy  
performed?

1 Yes 2X No

24b. Were autopsy findings available  
prior to completion of cause of  
death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1X Yes 2 No

Hospital:

1X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1X Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

VA 0102201129

29d. Date signed (Month, Day, Year)

03/09/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLOS RODRIGUEZ 22 S. GREENE STREET BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

2007 06336

Physician/ Medical Examiner

Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) Mark Robinson

2. Date of Death Month March Day 12 Year 2007

3. Time of Death 2305 hrs

4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center

4b. City, Town, or Location of Death Baltimore

4c. County of Death N/A

5. Social Security Number 214-78-8872

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 48 Yrs

8. Date of Birth (MM/DD/YYYY) Jan 28, 1959

9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland

10b. County N/A

10c. City, Town or Location Baltimore

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 2744 Harlem Ave.

10f. Zip Code 21216

10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Detailer

16b. Kind of Business/Industry Car Wash

17. Father's Name (First, Middle, Last) George Robinson

18. Mother's Name (First, Middle, Maiden Surname) Jean Gardner

19a. Informant's Name/Relationship (Type, Print) Jean Robinson - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2744 Harlem Ave. Baltimore, Maryland 21216

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery

20c. Location / City or Town, State Baltimore, Maryland

21. Signature of Funeral Service Licensee Kevin Parker

22. Name and Address of Facility Parker Funeral Home P.A. 21229 3512 Frederick Ave. Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 6 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) Mar 12, 2007

28b. Time of Injury 2209 hrs

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sidewalk

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2700 Block of Harlem Avenue, Baltimore, MD

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Zabiullah Ali, M.D. Assistant Medical Examiner

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) MAR 16 2007

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 08337

1- For State Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Horace

Staples

2. Date of Death

Month Day Year  
March 13, 2007

3. Time of Death

1237 hrs

4a. Facility Name (if not institution, give street and number)

5446 Addison Road

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

5. Social Security Number

579-40-4901

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Feb. 11, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5446 Addison Road

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lineman

16b. Kind of Business/Industry

Electric

17. Father's Name (First, Middle, Last)

(Unknown)

18. Mother's Name (First, Middle, Maiden Surname)

(Unknown)

19a. Informant's Name/Relationship (Type, Print)

Lewis Lively (Stepson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5446 Addison Road  
Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wood Memorial Park

Date

3/17/07

20c. Location - City or Town, State

Greer, SC

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Stibling Funeral Home  
118 W. Main St., Duncan, SC 29334

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED

☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Mar 13, 2007

28b. Time of Injury

FOUND: 1205 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5446 Addison Road, Capitol Heights, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

*[Signature]*

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08338

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Ann Sheppard

2. Date of Death

Month Day Year  
March 12, 2007

3. Time of Death

6:30 P M

4a. Facility Name (If not institution, give street and number)

1310 Fuselage Avenue

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214 34 4170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

8. Date of Birth (Month, Day, Year)

June 16, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1310 Fuselage Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alfred M. Green

18. Mother's Name (First, Middle, Maiden Surname)

Isabella Dick

19a. Informant's Name/Relationship (Type. Print)

Emery Sheppard (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1310 Fuselage Avenue Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gardens

Date

3/15/2007

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *non-small cell lung cancer*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
*7mo*

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36814

29d. Date signed (Month, Day, Year)

3/14/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard L. Husli 7505 Old Dr. Suites 22 Towson MD 21204

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

p. 1011. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 911.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division or Vital Records, P.O. Box 687600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08339

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Diane

Stevenson

2. Date of Death

Month

Day

Year

March

13

2007

3. Time of Death

1102

A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

220-64-5115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

8. Date of Birth (Month, Day, Year)

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

07 22 55

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4012 Walrad Street

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crossing Guard

16b. Kind of Business/Industry

Baltimore City School System

17. Father's Name (First, Middle, Last)

Walter McCoy

18. Mother's Name (First, Middle, Maiden Surname)

Irene Rice

19a. Informant's Name/Relationship (Type, Print)

Milton Stevenson Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4012 Walrad Street, Baltimore, Md 21215

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 3/19/07

Date

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Diana March

22. Name and Address of Facility

March F/H West  
4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. Metastatic Gastric Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 days

3 days

3 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Diana March Medical Doctor

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

El. Boritz, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Diana March

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DAMON M. SMITH

07-01908  
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2007 08340

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Damon

Marc

Smith

2. Date of Death  
Month Day Year  
March 11, 20073. Time of Death  
0123 hrsFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

213-88-5144

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

01 25 69

9. Birthplace (State or Foreign Country)

CT

Usual Residence of Decedent

10a. State  
MD10b. County  
NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5320 Maple Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Various Jobs

17. Father's Name (First, Middle, Last)

Murriel Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Deborah Smith

19a. Informant's Name/Relationship (Type, Print)

Deborah Smith-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5320 Maple Ave, Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

3/16/07

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Sala March

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wound of torso

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

UNPENDED

AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other:

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

Month, Day, Year

FOUND: Mar 11, 2007

28b. Time of Injury

FOUND: 0101 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Alley

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5000 Denmore Ave., Baltimore, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary G. Ripple MD.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 11, 2007

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Damon M. Smith

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08341

Physician/  
Medical Examiner

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

JESSIE LEE SALEM

2. Date of Death  
Month Day Year  
March 13, 2007

3. Time of Death  
0607 hrs

4a. Facility Name (if not institution, give street and number)

2807 Mosher Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-64-7496

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

JUNE 7, 1955

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2807 MOSHER STREET

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

GED

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

JANITOR

16b. Kind of Business/Industry

MAINTENANCE Co.

17. Father's Name (First, Middle, Last)

CHARLES

SALEM

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE BRADY

19a. Informant's Name/Relationship (Type, Print)

ANNIE SALEM (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1016 N. MONROE ST. BALTO. MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEME

Date

03-21-07

20c. Location - City or Town, State

LANSDOWNE, MD.

21. Signature of Funeral Service Licensee

Josephine E. Roane

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE. BALTIMORE MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED

☐ AMENDED

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol abuse

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Jesse Lee Salem

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- Amend Items 23a per dr. 8865, 03/15/07/dhb, Items 31, 21 per dvr  
 Certificate of Death Reg. No. 2007 00342

|   |   |  |  |  |  |  |   |  |  |
|---|---|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gene Tunney Shiflett</b>   |  |  | 2. Date of Death<br>Month Day Year<br><b>03/05/2007</b>  |  |  | 3. Time of Death<br><b>11:40 PM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-20-6625</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>08/12/1928</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |   |  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|   | 10e. Street and Number<br><b>125 1st Ave W</b>  |  |  | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Union Official</b>           |  |  | 16b. Kind of Business/Industry<br><b>Union</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas Shiflett</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lois Mundy</b>   |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Betty Shiflett / wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>125 1st Ave W; Glen Burnie, MD 21061</b> |  |  |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Cremation</b>  |  | 20c. Date<br><b>03/07/2007</b>   |   | 20d. Location - City or Town, State<br><b>Stevensville, MD</b> |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br><b>Singleton Funeral Home, PA<br/>1 Second Ave SW; Glen Burnie, MD 21061</b>                             |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrest Cardiac Arrhythmia</b><br>Due to (or as a consequence of): <b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |  |  |  |   |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Ronald Attanasio MD</b>   |   |  | 29c. License number<br><b>D-28097</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/6/07</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RONALD ATTANASIO 9114 Philadelphia Rd. Suite 108, Baltimore, Md. 21237.</b>  |   |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>3/6/07 MAR 16 2007</b>  |   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |

Shiflett Gene

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08343

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD

SOBUS

2. Date of Death

Month

Day

Year

3. Time of Death

3

13

2007

20:11 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

218-14-8332

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

2-8-1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1219 BERKWOOD ROAD

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

PORT OF BALTIMORE

17. Father's Name (First, Middle, Last)

PETER

SOBUS

18. Mother's Name (First, Middle, Maiden Surname)

ROZALIA

(MALIKOWSKA)

19a. Informant's Name/Relationship (Type, Print)

FRANCES SOBUS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1219 BERKWOOD ROAD ROSEDALE, MD 21237

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3-19-07

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME

1211 CHESACO AVE ROSEDALE, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Airway obstruction

Due to (or as a consequence of):

b. Inability to mobilize secretions

Due to (or as a consequence of):

c. PARKINSONISM

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth Eaddy MD

29c. License number

RES 0000

29d. Date signed (Month, Day, Year)

3/13/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KENNETH Eaddy 9000 Franklin Sq. drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08344

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Richard Lee Stuckey

2. Date of Death  
Month Day Year  
March 7, 20073. Time of Death  
1130 hrs

4a. Facility Name (if not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

218-27-8871

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

17 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Mn.

8. Date of Birth (MM/DD/YYYY)

January 30, 1990

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1643 Appleton Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Wayne Spriggs

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Stuckey

19a. Informant Name/Relationship (Type, Print)

Lucy Stuckey (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3442 Reisterstown Road Balto. Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Carmel Cemetery

Date

3/17/07

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Miller's Metropolitan Chapel P.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wound of head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury

(Month, Day, Year)

Mar 6, 2007

28b. Time of Injury

1920 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Sidewalk

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1115 North Ellamont Street, Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 10, 2007

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08345

1- For State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARTHA</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>11</b> Year <b>2007</b>  |  |   |  | 3. Time of Death<br><b>3:34 P M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>37 STONEHENGE CIRCLE APT. #4</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |  |  |
| 5. Social Security Number<br><b>218-16-1747</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11/4/1925</b> |  | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  |  |  |
| 10a. State<br><b>MD</b>  |  |  |  | 10b. County<br><b>BALTIMORE</b>  |  |   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>37 STONEHENGE CIRCLE #4</b>   |  |   |  | 10f. Zip Code<br><b>21208</b>  |  |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>REALTOR</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>REAL ESTATE</b>   |  |   |  | 17. Father's Name (First, Middle, Last)<br><b>DAVID SHAPIRO</b>  |  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TILLIE KLING</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DAVID FOX/SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 HENDERSON HILL; MONKTON, MD 21111</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR SINAI</b>   |  |   |  | 20c. Location - City or Town, State<br><b>3/14/2007 WINGS MILLS, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN RD; BALTIMORE, MD 21208</b>  |  |   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Chronic Obstructive Pulmonary Disease 15 years</b>                     |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cor Pulmonale</b>   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
| 28a. Date of Injury (Month, Day Year)  |  |  |  | 28b. Time of Injury<br><b>M</b>  |  |   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D36356</b>   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>March 12, 2007</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert B. Shochet MD 2360 West Joppa Rd Lutherville MD 21093</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |  |  |
| 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |  |  |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2007 08346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Fred D. Shupe 2. Date of Death Month March 11, 2007 Day Year 3. Time of Death 3:19 p M

Funeral Director

4a. Facility Name (If not institution, give street and number) 218 Willow Avenue 4b. City, Town, or Location of Death Towson 4c. County of Death Baltimore

5. Social Security Number 225-38-3727 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 74 Yrs. 8. Date of Birth (Month, Day, Year) Dec 31, 1932 9. Birthplace (State or Foreign Country) Virginia

Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 218 Willow Avenue 10f. Zip Code 21286 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Car Salesman 16b. Kind of Business/Industry Automobile

17. Father's Name (First, Middle, Last) Fred D. Shupe Sr. 18. Mother's Name (First, Middle, Maiden Surname) Effie Lyons

19a. Informant's Name/Relationship (Type, Print) Charles D. Thomas-nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Ebenezer Rd., Middle River, MD 21220

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Serv Corp 20c. Location - City or Town, State Towson, MD

21. Signature of Funeral Service Licensed William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. H A S C V D Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS Type II 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH, 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G.S. PRABHU MD 2336 YORK RD TIMONUM MD 21093

31. Date filed (Month, Day, Year) MAR 16 2007 32. Registrar's Signature

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08347

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

ENRICO Tumminello

2. Date of Death  
Month Day Year  
3 13 2007

3. Time of Death  
9:20 PM

4a. Facility Name (If not institution, give street and number)

OAK Crest

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral Director

5. Social Security Number

218-03-9689

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 17, 1917

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther, Blvd

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Self employed

17. Father's Name (First, Middle, Last)

Carmelo

Tumminello

18. Mother's Name (First, Middle, Maiden Surname)

Rosa

Brocato

19a. Informant's Name/Relationship (Type, Print)

Samuel Tumminello-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Glamis Garth, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley

Date

3/17/07

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

William G. Dau

22. Name and Address of Facility Ruck Towson Funeral Home, Inc.

1050 York Rd., Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Myelodysplastic Syndrome

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D61785

29d. Date signed (Month, Day, Year)

3/14/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Etoha Dixon, MD

8800 Walther Boulevard Parkville, MD 21234

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State Registrar

TUMMINELLO ENRICO 3-13-07 9:20PM

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08348

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Bernadine I. West

2. Date of Death  
Month Day Year  
March 14, 2007

3. Time of Death  
1230 PM

4a. Facility Name (If not institution, give street and number)

8222 Dundalk Avenue

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral Director

5. Social Security Number

212-34-7007

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 28, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8222 Dundalk Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Building Guard

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Author Grace

18. Mother's Name (First, Middle, Maiden Surname)

Dora Snyder

19a. Informant's Name/Relationship (Type, Print)

Harry J. West Jr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8222 Dundalk Avenue, Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery

Date  
March 17, 2007

20c. Location - City or Town, State

Rosedale, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
16 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D37612

29d. Date signed (Month, Day, Year)

March 15 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. ALABRASH, MD 1601 South Tollgate Rd Bel Air MD 21015

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08349

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FLORENCE

2. Date of Death

MARCH 12 2007

3. Time of Death

3:46 P M

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

WARTOW

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-07-9725

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

11/09/1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

305 WYNDHAM CIRCLE UNIT I

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

HOUSEWIFE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

CELIA

HAMBURG

19a. Informant's Name/Relationship (Type, Print)

FRANCINE WARTOW / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 WYNDHAM CIRCLE UNIT I - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK

Date

03/14/2007

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

▶ Matt Le

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Acute Myocardial infarction

Approximate Interval Between Onset and Death

acute

b. Due to (or as a consequence of):

Coronary artery disease

10 yrs.

c. Due to (or as a consequence of):

ASCVD

20 yrs.

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Herbert Gerald Oster MD

29c. License number

D-16090

29d. Date signed (Month, Day, Year)

3-13-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERBERT GERALD OSTER 36350 Court Road Bldg. MD 21208

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

▶ [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08350

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Eva Young

2. Date of Death

March 7, 2007

3. Time of Death

8:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Ft. Washington Health &amp; Rehab

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince George's

5. Social Security Number

229-40-6519

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 6, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7314 Leyte Drive

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Housekeeper

17. Father's Name (First, Middle, Last)

Peter Sherman Young

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Corr Bush

19a. Informant's Name/Relationship (Type, Print)

Floraine Eva Cunningham /Dau

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7314 Leyte Drive, Oxon Hill, MD 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olive Bapt. Church 3-14-07

Date

20c. Location - City or Town, State

Hustle, VA

21. Signature of Funeral Service Licensee

Dennis Pottman

22. Name and Address of Facility

Washington Funeral Home  
P.O. Box 476 Tappahanock, VA 22560

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):b. Parkinson Disease  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week  
1 1/2 yr

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Pottman

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

03, 12, 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxima Berwa, MD 7700 Old Branch Ave #101 Clinton, MD 20735

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Dennis Pottman

State  
Registrar

Baltimore, Maryland 21215-0036

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08351  
March 7, 2007  
4:26 P M1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Ignatius Arnsworthy, Jr.

2. Date of Death

March 7, 2007

3. Time of Death  
4:26 P M

4a. Facility Name (If not institution, give street and number)

22621 Three Notch Road

4b. City, Town, or Location of Death

California

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

220-22-9331

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

February 17, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22621 Three Notch Road

10f. Zip Code

20619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Gas Company

17. Father's Name (First, Middle, Last)

William Ignatius Arnsworthy, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Susie C. Hayden

19a. Informant's Name/Relationship (Type. Print)

Evelyn Anna Mae Arnsworthy / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22621 Three Notch Road, California, Maryland 20619

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Face Cemetery

Date

March 12, 2007

20c. Location - City or Town, State

Great Mills, Maryland

21. Signature of Funeral Service Licensee

Michael K. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II diabetes, right sided congestive heart failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

attending

29c. License number

D0055682

29d. Date signed (Month, Day, Year)

3/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas M. Wilkins, MD 23140 Monkley St. Suite 2, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

MAR 09 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend # 12 &amp; #16a &amp; #16b per CH/PHYS 03-05-2007

Reg. No. 2007 08352

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM A ALLEN

2. Date of Death

Month Day Year  
MARCH 02 2007

3. Time of Death

9:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NIA

5. Social Security Number

212-50-9365

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3-25-1947

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 EAST 6TH ST Apt 2

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HANDYMAN/LABORER

16b. Kind of Business/Industry

Laborer

17. Father's Name (First, Middle, Last)

RAYMOND A. ALLEN

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA GREEN

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA SMITH (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 B APT 1 WEST SOUTH ST FREDERICK MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FAIRVIEW CEM.

Date

3-10-07

20c. Location - City or Town, State

FREDERICK MD.

21. Signature of Funeral Service Licensee

▶ Gary L. Follett

22. Name and Address of Facility

GARY L. FOLLETT  
110 WEST SOUTH ST FREDERICK MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

SEPSIS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ [Signature] M.D.

29c. License number

17410

29d. Date signed (Month, Day, Year)

MARCH 2, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW DORSCH UMMC 22 S GREENE ST BALTIMORE, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08353

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>James W. Alvanos  |  | 2. Date of Death<br>Month: February, Day: 28, Year: 2007  |   | 3. Time of Death<br>7:00 P <sup>M</sup>   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Charlotte Hall Veterans Home  |  | 4b. City, Town, or Location of Death<br>Charlotte Hall  |   | 4c. County of Death<br>St. Mary's   |  |
| 5. Social Security Number<br>230-05-3907  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>87 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>March 29, 1919               |   | 9. Birthplace (State or Foreign Country)<br>Virginia |
| Usual Residence of Decedent   |  |   |   |   |  |
| 10a. State<br>Maryland  | 10b. County<br>St. Mary's  | 10c. City, Town or Location<br>Charlotte Hall   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br>29449 Charlotte Hall Rd.  |  | 10f. Zip Code<br>20622  |   | 10g. Citizen of What Country?<br>U S A  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4 or 5+):   |   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Security Guard   |  | 16b. Kind of Business/Industry<br>Bank  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>William Alvanos  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia White |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mary Albert/Niece   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>121 Hampshire Dr., Cranberry Twp., PA 16066  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Brinsfield-Echols Crem. March 3, 2007   |   | 20c. Location - City or Town, State<br>Charlotte Hall, MD   |  |
| 21. Signature of Funeral Service Licensee<br>[Signature] M000641  |  | 22. Name and Address of Facility<br>Brinsfield-Echols F.H., P.A.,<br>30195 Three Notch Rd., Charlotte Hall, MD 20622  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Advanced Dementia<br>Due to (or as a consequence of):<br>b. Wernicke's Encephalopathy<br>Due to (or as a consequence of):<br>c. Coronary Artery Disease<br>Due to (or as a consequence of):<br>d. Hypertension |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown                        |   | 23d. Date of delivery<br>Month: Day: Year:  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>hyperlipidemia<br>Anemia<br>Peptic Ulcer disease  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>5 Pending investigation<br>6 Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |   |  |
| 29b. Signature and title of certifier<br>[Signature] Paul [Signature]   |  | 29c. License number<br>D45092   |   | 29d. Date signed (Month, Day, Year)<br>3/6/2007   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>110 Hospital Rd Suite #205 Prince Fredrick, MD  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 07 2007  |  | 32. Registrar's Signature<br>[Signature]  |   |   |  |

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2007 08354

|  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
|--|--|--|---|---------------------------------|--|--|--|-----------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian T. Brundick</b>   |  |   |                                 | 2. Date of Death<br>Month <b>FEB.</b> Day <b>27</b> Year <b>2007</b>   |  |  |                                   | 3. Time of Death<br><b>1355-M</b>  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  |   |                                 | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |  |  |                                   | 4c. County of Death<br><b>Wicomico</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-28-2762</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                 | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>8-25-1933</b>  |                                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
|  | Usual Residence of Decedent  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Delaware</b>  |  | 10b. County<br><b>Sussex</b>  |                                 | 10c. City, Town or Location<br><b>Laurel</b>   |  |  |                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br><b>15825 Trap Drive</b>  |  |   |                                 | 10f. Zip Code<br><b>19956</b>  |  |  |                                   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |                                   | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Jin Der</b>  |  |   |                                 |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marian Warley</b>  |                                   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Calvin Brundick, Sr./Husband</b>  |  |   |                                 |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15825 Trap Drive Laurel, De. 19956</b> |                                   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crematory of Delmarva</b>   |  |  |                                   | 20c. Location - City or Town, State<br><b>2-28-2007 Delmar, Delaware</b>                           |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Helen Short-Hannigan</i>   |  |   |                                 |  |  | 22. Name and Address of Facility<br><b>Hannigan-Short-Disharoon F.H. 700 West Street Laurel, De. 19956</b>                                 |                                   |  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SMALL CELL LUNG CARCINOMA</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                 |  |  |  |                                   |  |  |  |  |
|  | 23b. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 23c. Date of delivery<br>Month Day Year  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC RENAL INSUFFICIENCY</b>   |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 28a. Date of Injury (Month, Day Year)  |  |  |   | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Sgt. M.D.</i>  |  |  |   |                                 |  | 29c. License number<br><b>D0062916</b>   |  |                                   | 29d. Date signed (Month, Day, Year)<br><b>Feb. 28, 2007</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SVETLANA GUTIERREZ MD 1415 South Division St. Salisbury Md 21804</b>  |  |  |   |                                 |  |  |  |                                   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  |  |   |                                 |  | 32. Registrar's Signature<br><i>James H. Smith</i>                                   |  |                                   |  |  |  |  |

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08355

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Broidy

2. Date of Death

March 7, 2007

3. Time of Death

12:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2240 Community Drive

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

5. Social Security Number

579-58-6728

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 5, 1947

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2240 Community Drive

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Human Resource Specialist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Clarence Roach

18. Mother's Name (First, Middle, Maiden Surname)

Corrine Medley

19a. Informant's Name/Relationship (Type, Print)

Antonio Haskins / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2240 Community Drive Waldorf, Maryland 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

03/13/2007

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

George P. Kalas Funeral Home PA

6160 Oxon Hill Road Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

METASTATIC GASTRIC CANCER

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Smoker, Rectal bleed, Malnutrition

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D GIL14

29d. Date signed (Month, Day, Year)

MARCH 8th 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Sindhwani MD 11350 Pembroke Square Waldorf, Maryland

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, F&amp;P

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08356

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Urban Billing, Sr.

2. Date of Death  
Month Day Year  
March 2, 20073. Time of Death  
10:10P MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

ST. Mary's

5. Social Security Number

218-14-8047

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 5, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4114 Morovia Rd.

10f. Zip Code

21206

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1943-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Shipping Building

17. Father's Name (First, Middle, Last)

John Billing

18. Mother's Name (First, Middle, Maiden Surname)

Emma Weston

19a. Informant's Name/Relationship (Type, Print)

Louis Billing, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4114 Morovia Rd., Baltimore, MD 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Brinsfield-Echols Crem. 2007

Date

March 6,

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

John Billing, Jr.

22. Name and Address of Facility

Brinsfield-Echols F.H., P.A.,  
30195 Three Notch Rd., Charlotte Hall, MD 20622

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Rt. Lung collapse / Pneumonia

Due to (or as a consequence of):

b. hypoxia

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Peripheral Vascular Disease

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes mellitus  
Hypertension  
Left Bundle Branch Block

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Sam

29c. License number

D45092

29d. Date signed (Month, Day, Year)

3/6/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road Suite #205 Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's Signature

John B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08357

1- For State Registrar

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wynn Harper Bixby

2. Date of Death

February 28 2007

3. Time of Death

2300 PM

4a. Facility Name (If not institution, give street and number)

Chester River Hospital Center

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

169-40-9730

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

06/08/1949

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22467 GOOSE HOLLOW DRIVE

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

DISTRIBUTION

17. Father's Name (First, Middle, Last)

JOCK WOOD BIXBY

18. Mother's Name (First, Middle, Maiden Sumame)

VERNE CUTHBERT

19a. Informant's Name/Relationship (Type, Print)

BARBARA A. BIXBY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22467 GOOSE HOLLOW DRIVE, CHESTERTOWN, MD 21620

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

03/02/2007

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

*Joseph Jellison*

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME, PA  
130 SPEER ROAD, CHESTERTOWN, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. WIDELY METASTATIC ADENOCARCINOMA, ESOPHAGOS

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BILATERAL PULMONARY EMBOLI

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Helen A. Noble*

29c. License number

D0041587

29d. Date signed (Month, Day, Year)

3/1/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELEN NOBLE, MD 122 SPEER RD CHESTERTOWN, MD 21620

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar Signature

*John A. Ford*

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08358

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA L. BARTON

2. Date of Death

Month Day Year  
February 25 2007

3. Time of Death

2:30A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BRADFORD OAKS NURSING HOME

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

579-34-9821

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 2 1919

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4519 SHERBORN LANE

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

JUDE WALKER

18. Mother's Name (First, Middle, Maiden Surname)

EMMA GREEN

19a. Informant's Name/Relationship (Type, Print)

ORIS WYATT SR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4519 SHERBORN LANE UPPER MARLBORO, MD 20772

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY CEMETERY

Date

3/5/2007

20c. Location - City or Town, State

Landover, Md

21. Signature of Funeral Service Licensee

K. D. Hall

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D19431

29d. Date signed (Month, Day, Year)

02-26-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Ryan M.D. 11701 Livingston Road # 103 Fort Washington, Maryland 20744

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

B. D. Hall

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08359

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Ronald Bible

2. Date of Death  
Month Day Year

03 03 07

3. Time of Death

2157 M

4a. Facility Name (If not institution, give street and number)

WMHS Braddock Campus

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-32-2798

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

8. Date of Birth (Month, Day, Year)

11/08/1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Flintstone

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22601 Gilpin Road, NE

10f. Zip Code

21530

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1953-1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Airplane Mechanic

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Frederick Madison Bible

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Roxie Price

19a. Informant's Name/Relationship (Type, Print)

R. Dale Bible / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19007 W. Lynnwood Street, Buckeye, AZ 85396

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Vet. Cem @ Rocky Gap 03/09/2007 Flintstone, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Adams Family Funeral Home, P.A.  
404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Cancer

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vik Poonai

29c. License number

D36766

29d. Date signed (Month, Day, Year)

MARCH 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

K. H. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.1-VA  
not.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Sara Jean Bridges

2. Date of Death

Month Day Year  
March 5, 2007

3. Time of Death  
11:25 A M

Funeral Director

4a. Facility Name (If not institution, give street and number)

701 Fourth Street, Apt. 318

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

217-28-9096

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10/25/1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

701 Fourth Street, Apt. 318

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles Henry

Swearman

18. Mother's Name (First, Middle, Maiden Surname)

Maude V.

Bittner

19a. Informant's Name/Relationship (Type, Print)

Linda Shank / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16016 Foundry Row, Mt. Savage, MD 21545

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

03/06/2007

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

*Robert C. Adams*

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

COPD

b. Due to (or as a consequence of):

Tobacco abuse

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
year  
year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Anthony J. Bollino, Jr.*

29c. License number

D17565

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Bollino, Jr., M.D., 922 National Highway, LaVale, MD 21502

State Registrar

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

*Robert C. Adams*

ok for me  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  
Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08361

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley R. Brown

2. Date of Death

February 28, 2007

3. Time of Death

2:55 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

219-32-3485

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 18, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1011 President Street

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

George Brown

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Green

19a. Informant's Name/Relationship (Type, Print)

Venessa Brown/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 President Street Annapolis, Maryland 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hillcrest Mem. Gardens

Date

3/6/2007

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home  
147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYELOPROLIFERATIVE DISORDER

RENAL FAILURE

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

T. M. M.D.

29c. License number

D0051437

29d. Date signed (Month, Day, Year)

02/28/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DKEOWO DARTY IBITORE AFMC 2001 MEDICAL PARKWAY MD 21401

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08362

1- For State Registrar

Physician/  
Medical Examiner

|  |  |  |  |                                     |
|--|--|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert D. Clark</b> |  | 2. Date of Death<br>Month <b>March</b> Day <b>6</b> Year <b>2007</b> |  | 3. Time of Death<br><b>0825 hrs</b> |
|--|--|--|--|-------------------------------------|

Funeral  
Director

|  |  |  |   |  |
|--|--|--|---|--|
| 4a. Facility Name (if not institution, give street and number)<br><b>Peninsula Regional Hospital</b> |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b> |   | 4c. County of Death<br><b>Wicomico</b>             |
| 5. Social Security Number<br><b>219-62-8272</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.         | 8. Date of Birth (MM/DD/YYYY)<br>Month <b>May</b> Day <b>4</b> Year <b>1955</b> | 9. Birthplace (State or Foreign Country) <b>PA</b> |

|                             |                                |  |  |
|-----------------------------|--------------------------------|--|--|
| Usual Residence of Decedent |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10a. State<br><b>MD</b>     | 10b. County<br><b>Wicomico</b> | 10c. City, Town or Location<br><b>Salisbury</b>  |  |

|   |                               |  |
|---|-------------------------------|--|
| 10e. Street and Number<br><b>3722 Union Church Road</b> | 10f. Zip Code<br><b>21801</b> | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|---|-------------------------------|--|

|  |   |   |   |
|--|---|---|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |
|--|---|---|---|

|  |   |   |
|--|---|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bartender</b> | 16b. Kind of Business/Industry<br><b>Restaurant</b> |
|--|---|---|

|  |   |
|--|---|
| 17. Father's Name (First, Middle, Last)<br><b>Chester H. Clark</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Valentino</b> |
|--|---|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert P. Clark (Son)</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>113 White Street Salisbury, MD 21804</b> |
|--|--|

|  |  |  |
|--|--|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Springhill Memory Gardens</b> | 20c. Location - City or Town, State<br><b>Hebron, Maryland</b> |
|--|--|--|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br><i>Corey Short-Jewell</i> | 22. Name and Address of Facility<br><b>Short Funeral Home<br/>13 E. Grove Street Delmar, DE 19940</b> |
|--|---|

Physician  
/Medical  
Examiner

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Intracerebral hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. #23a, PII, 27, per ME, g865, 3/17/07 TT</b><br>Due to (or as a consequence of):<br><b>c. #23a, PII, 27, per ME, g865, 3/17/07 TT</b><br>Due to (or as a consequence of):<br><b>d. #23a, PII, 27, per ME, g865, 3/17/07 TT</b> | Approximate Interval Between Onset and Death |
|---|--|

|   |   |   |
|---|---|---|
| 23b. If FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month <b>March</b> Day <b>9</b> Year <b>2007</b> |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cocaine use</b><br><b>Hypertensive atherosclerotic cardiovascular disease</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|--|

|   |  |                     |  |                                   |
|---|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|---|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |   |  |   |
|--|---|--|---|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier<br><i>Ling Li, M.D.</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>March 9, 2007</b> |
|--|---|--|---|

|  |  |  |  |
|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b> |  |  |  |
|--|--|--|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 2007</b> | 32. Registrar's Signature<br><i>Sean H. Spivey</i> |
|---|--|

State Registrar

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State of Maryland / Department of Health and Mental Hygiene

2007 08363

1-

For State Registrar #31 per wichd/3-2-07/dls

## Certificate of Death

Reg. No.

**Physician /Medical Examiner**  
1. Decedent's Name (First, Middle, Last)  
**William J. Collicke**  
2. Date of Death  
Month **02** Day **28** Year **07** 02:00 P M  
3. Time of Death

**Funeral Director**  
4a. Facility Name (If not institution, give street and number)  
**1210 Market Street Apt. G4**  
4b. City, Town, or Location of Death  
**Pocomoke City**  
4c. County of Death  
**Worcester**  
5. Social Security Number  
**141-24-1947**  
6. Sex  
☒ M ☐ F  
7. Age (In yrs. last birthday)  
**74**  
8. Date of Birth (Month, Day, Year)  
**5-2-32**  
9. Birthplace (State or Foreign Country)  
**md**

**To Be Completed by Funeral Director**  
10a. State  
**md**  
10b. County  
**Worcester**  
10c. City, Town or Location  
**Pocomoke**  
10d. Inside City Limits  
☒ Yes ☐ No  
10e. Street and Number  
**1210 Market Street Apt. G4**  
10f. Zip Code  
**21851**  
10g. Citizen of What Country?  
**U.S.A.**  
11. Marital Status  
☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
☒ Yes ☐ No **1951**  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:  
14. Race - American Indian, Black, White, etc.  
Specify: **Black**  
15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) **8th** College (1-4 or 5+)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
**Production worker**  
16b. Kind of Business/Industry  
**Dresser Wayne**  
17. Father's Name (First, Middle, Last)  
**David Lee Pitts**  
18. Mother's Name (First, Middle, Maiden Surname)  
**Edna U. Mosley**  
19a. Informant's Name/Relationship (Type, Print)  
**Anna McIntosh (Aunt)**  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**30101 Kristwood Way Princess Anne md. 21851**  
20a. Method of Disposition  
☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place)  
**Coalspring Cem.**  
20c. Location - City or Town, State  
**3-10-07 Girdletree md.**  
21. Signature of Funeral Service Licensee  
**Dr. [Signature]**  
22. Name and Address of Facility  
**Bennie Smith Funeral Home P.O. Box 331 Pocomoke City, md. 21851**

**Physician /Medical Examiner**  
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
**a. METASTATIC LUNG CANCER**  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
**b. Due to (or as a consequence of):**  
**c. Due to (or as a consequence of):**  
**d. Due to (or as a consequence of):**  
IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown  
23d. Date of delivery  
Month Day Year  
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
23e. Did tobacco use contribute to the cause of death?  
☐ Yes ☐ No ☒ Probably ☐ Unknown  
24a. Was an autopsy performed?  
☐ Yes ☒ No  
24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No  
25. Was case referred to medical examiner?  
☐ Yes ☒ No  
26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)  
27. Manner of Death  
☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury  
M  
28c. Injury at Work?  
☐ Yes ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)  
29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Signature and title of certifier  
**Satyar MD**  
29c. License number  
**D0062172**  
29d. Date signed (Month, Day, Year)  
**3/2/2007**  
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**SHARAD R SATYAL, MD 1604 MARKET ST. POCOMOKE MD 21851**  
31. Date filed (Month, Day, Year)  
**JAN 31 2007**  
32. Registrar's Signature  
**[Signature]**

**State Registrar**

DHH 17 Rev 1/2001

MAR 02 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08366

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oliver James Collier

2. Date of Death

February 27 2007

3. Time of Death

7:05 PM<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

215-20-1209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

7-19-25

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md. Wicomico

10b. County

Fruitland

10c. City, Town or Location

Fruitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

219 N. Dulaney Avenue

10f. Zip Code

21820

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Oliver Collier

18. Mother's Name (First, Middle, Maiden Surname)

Rena Jones

19a. Informant's Name/Relationship (Type, Print)

Dtha Lee Harris (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

219 N. Dulaney Ave. Fruitland Md. 21820

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Cen.

Date

3-3-07

20c. Location - City or Town, State

Hebron Md.

21. Signature of Funeral Service/Li

[Signature]

22. Name and Address of Facility

Bernice Smith Funeral Home  
917 Zerkow Street Salisbury Md. 21801

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

CVA.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERGLYCEMIA.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yogesh M.D.

29c. License number

00063199

29d. Date signed (Month, Day, Year)

02/28/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yogesh Vohra M.D. 614 Eastern Dr Salisbury MD 21804

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

State  
RegistrarOliver Collier  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08365

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Austin M. Cummings</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>8</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>5:20 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |   | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>502-05-6428</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>88</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>09/12/1918</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>ND</b>   |   |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>WASHINGTON</b>  |   | 10c. City, Town or Location<br><b>WILLIAMSPORT</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>C-1, 16505 VIRGINIA AV.</b>  |   | 10f. Zip Code<br><b>21795</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EXPLOSIVES SPECIALIST</b>   |   | 16b. Kind of Business/Industry<br><b>E. I. DuPONT</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>AUSTIN G. CUMMINGS</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA CROONQUIST</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELIZABETH CUMMINGS / WIFE</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>C-1, 16505 VIRGINIA AV., WILLIAMSPORT, MD 21795</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEDGESVILLE CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>03/12/2007 HEDGESVILLE, WV</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Charles M. Brown</b>   |  | 22. Name and Address of Facility<br><b>BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypoxia</b><br>Due to (or as a consequence of):<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Severe Clostridium Difficile Colitis</b><br>Due to (or as a consequence of): |  |   |   |  |  |
| Approximate Interval Between Onset and Death   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NOSOCOMIAL PNEUMONIA</b><br><b>atrial fibrillation with rapid ventricular response</b><br><b>acute renal failure</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>MS GORD</b>  |  | 29c. License number<br><b>00053071</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>03/08/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARK EDSON MD, 851 E. PATTERSON ST, HAGERSTOWN, MD 21740</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  |   |   |  |  |
| 32. Registrar's Signature<br><b>John B. Smith</b>  |  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 442

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08366

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Tangue rite

Carmach

2. Date of Death

March 7, 2007

3. Time of Death

6:15 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

College View Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-3276

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103 Yrs.

8. Date of Birth

June 14, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8130 Dolly Hyde Road

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William Christopher Woerner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Davis

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Norris, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8130 Dolly Hyde Road, Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

3/10/2007

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Ryan M. Beyer

22. Name and Address of Facility

Keeney and Basford Funeral Home

M00999 106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt; 10y

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hemen Shah

29c. License number

D0060417

29d. Date signed (Month, Day, Year)

3-8-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shah up. 65 c Thomas Johnson Dr Frederic MD 21702

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

Ryan M. Beyer

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 443

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08367

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |
|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lena Marie Costley</b>                             |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>12:30 P M</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6251 Oxon Hill Road #103</b> |   |  | 4b. City, Town, or Location of Death<br><b>Oxon Hill</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-68-5118</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 17, 1949</b> |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                                 |   |  |  |  |  |  |
| Usual Residence of Decedent  |   |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Oxon Hill</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6251 Oxon Hill Road #103</b>  |   |   |  | 10f. Zip Code<br><b>20745</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>   |  | 16b. Kind of Business/Industry<br><b>Park University</b>                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>Augustus Jasper</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Henrietta Thompson</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frank Costley / Husband</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6251 Oxon Hill Road #103 Oxon Hill, Maryland 20745</b>                                   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b>  |  | Date<br><b>03/14/2007</b>  |  | 20c. Location - City or Town, State<br><b>Edgewater, Maryland</b>                              |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home PA<br/>6160 Oxon Hill Road Oxon Hill, Maryland 20745</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC BREAST CANCER</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>12/2006 - 3/2007</b>  |   |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown  |   |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D59942</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 13, 2007</b>                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Deepnarayan Tiwari 8926 Woodyard Rd #201 Clenton, MD 20735</b>  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |   |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08368

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Trenton Elijah Colbert

2. Date of Death

March

Day

1

Year

2007

3. Time of Death

2:31 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

5. Social Security Number

none

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

31

8. Date of Birth (Month, Day, Year)

March

Day

1

Year

2007

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

53 East Franklin Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

N/A

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Not Stated

18. Mother's Name (First, Middle, Maiden Surname)

Jessica Colbert

19a. Informant's Name/Relationship (Type, Print)

Jessica Colbert (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 East Franklin St. Hagerstown Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem Park

Date

3-9-2007

20c. Location - City or Town, State

Hagerstown Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd. N. Hagerstown Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prematurity 29.4 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Multiple Congenital Anomalies

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hydrocephalus, Absent @ Kidney, Absent bladder  
Stomach shadow, Aortic Stenosis, Pericardiac effusion,  
Pulmonary Hypoplasia on fetal ultrasound.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-64455

29d. Date signed (Month, Day, Year)

3/1/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zia Uddin, MD

Washington County Hospital

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08370

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Hugh Christie

2. Date of Death

03/02/07

Day

Year

3. Time of Death

0116 amM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

441-46-1385

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/1/1940

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1□Yes 2XNo

10e. Street and Number

5 Drawbridge Rd.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1□Never Married 2XMarried

3□Widowed 4□Divorced

12. Was Decedent Ever in U.S.

1XYes 2□No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2XNo Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Consultant

16b. Kind of Business/Industry

Computer Industry

17. Father's Name (First, Middle, Last)

Robert Hugh Christie, SR.

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Fenlon

19a. Informant's Name/Relationship (Type, Print)

Helen Christie / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Drawbridge Rd., Berlin, MD 21811

20a. Method of Disposition

1□Burial 2XCrementation 3□Removal from State

4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of cemetery, funeral home, or other place)

Cape Henry Crem.

Date

3/2/2007

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 William St., Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of liver.

Due to (or as a consequence of):

Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1□Yes 2□No

9□Unknown

23c. If yes, outcome of pregnancy

1□Live birth 2□Fetal death

4□Pregnant at time of death

9□Unknown

3□Ectopic pregnancy

5□Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis.

23e. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3□Probably 4XUnknown

24a. Was an autopsy performed?

1□Yes 2XNo

24b. Were autopsy findings available prior to completion of cause of death?

1□Yes 2□No

25. Was case referred to medical examiner?

1□Yes 2XNo

Hospital:

1XInpatient

2□ER/Outpatient

3□DOA

Other:

4□Nursing Home

5□Residence

6□Other (Specify)

27. Manner of Death

1XNatural

2□Accident

3□Suicide

4□Homicide

5□Pending investigation

6□Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□Yes 2□No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D0064120

29d. Date signed (Month, Day, Year)

03/02/07.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATIF ZEBESHAN AGH 9733 Healthway Drive Berlin MD 21811

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Brian B. Sparks

State  
RegistrarDOB - 12/01/1940  
DOB - 03/02/2007  
Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Robert H. Christie  
441-46-1385  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Kathryn Mae Cottrill

2. Date of Death

Month Day Year  
March 9, 2007

3. Time of Death

1307 hrs

4a. Facility Name (if not institution, give street and number)

Easton Memorial

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

215-62-1437

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

3-30-1954

9. Birthplace (State or Foreign Country)

Easton, Md

Usual Residence of Decedent

10a. State

Md

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5980 Newton Road

10f. Zip Code

21655

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Walter E. Saunders

18. Mother's Name (First, Middle, Maiden Surname)

Jane Keys

19a. Informant's Name/Relationship (Type, Print)

Clarence D. Cottrill (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5980 Newton Rd. Preston, Md. 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Olivet Cemetery

Date

3-14-2007

20c. Location - City or Town, State

St. Michaels, Md.

21. Signature of Funeral Service Licensee

R. Carroll Hurley

22. Name and Address of Facility

R. Carroll Hurley Funeral Home PC  
P. O. Box 518, St. Michaels, Md. 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☒ AMENDED #19a, 19b per F.H., TCHD, 03/13/07, sbb

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Narcotic (Fentanyl) Treatment

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 3/9/2007

28b. Time of Injury

Fnd 1:00 pm

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject fell asleep in bathtub

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) House

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5980 Newton Road Preston, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 10, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 13 2007

32. Registrar's Signature

[Signature]

State Registrar



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00372

1- For State Registrar

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Anne Davis

2. Date of Death  
Month Day Year  
March 7, 20073. Time of Death  
1805 hrs

4a. Facility Name (if not institution, give street and number)

1403 C Sage Lane

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

118-50-4068

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

04/04/1957

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belcamp

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1403C Sage Lane

10f. Zip Code

21017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inventory Control

16b. Kind of Business/Industry

Retail  
Saks Fifth Avenue

17. Father's Name (First, Middle, Last)

Walter Mercer

18. Mother's Name (First, Middle, Maiden Surname)

Marylynn Mathews

19a. Informant's Name/Relationship (Type, Print)

Michael Mercer/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Singingwood Dr., Holbrook, NY 11741

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

3/8/07

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Thompson CFSP

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver cirrhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, per ME, g865, 3/17/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 13 2007

32. Registrar's Signature

Kathleen A. Davis

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |                                |  |   |
|---|--|--|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joan Marie Darragh</b>   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>8</b> , Year <b>2007</b>   |                                | 3. Time of Death<br><b>1250 P M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>94 River Road</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |                                | 4c. County of Death<br><b>Cecil</b>  |   |
| 5. Social Security Number<br><b>211-28-2248</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>AUG 12, 1937</b>   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
| Usual Residence of Decedent   |  |  |  |  |                                |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Elkton</b>   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>94 River Road</b>  |  |  |  | 10f. Zip Code<br><b>21921</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Associate</b>  |                                | 16b. Kind of Business/Industry<br><b>Technical Manufacturing</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>William A. Clarkson</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Mower</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine M. Kempski/Friend</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1171 Appleton Road, Elkton, Maryland 21921</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. Ferris &amp; Co. Inc.</b>  |  | Date<br><b>March 9, 2007</b>   |                                | 20c. Location - City or Town, State<br><b>West Chester, Pennsylvania</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Donna S. Hicks</b>  |  |  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton Street, Elkton, Maryland 21921</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac arrest</b><br>Due to (or as a consequence of):<br>b. <b>Kidney failure</b><br>Due to (or as a consequence of):<br>c. <b>Dehydration</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |                                |  | Approximate Interval Between Onset and Death                    |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown            |  | 23d. Date of delivery<br>Month Day Year  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Stroke</b>   |  |  |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |                                |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><b>Dr. Oksayan MD</b>  |  |  |  | 29c. License number<br><b>D00060756</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>3/9/2007</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ozden Oksayan MD 223 W Main St. Elkton, MD.</b>  |  |  |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |  |  |  | 32. Registrar's Signature<br><b>Donna S. Hicks</b>   |                                |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08374

Amended#26,

1- For State Registrar 3/5/07, MS, Kent Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT EDWIN DEEMER JR</b>  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 1 2007</b>  |  | 3. Time of Death<br>M<br><b>1215</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>CHESTER RIVER HOSPITAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>CHESTERTOWN</b>   |  | 4c. County of Death<br><b>KENT</b>  |  |
| 5. Social Security Number<br><b>218-26-7000</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>05/23/1930</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
| Usual Residence of Decedent  |  |  |  |   |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>QUEEN ANNE'S</b>   | 10c. City, Town or Location<br><b>MILLINGTON</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>22215 RED LION BRANCH ROAD</b>  |  | 10f. Zip Code<br><b>21651</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                    |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MACHINICIST/MECHANIC</b>  |  |
| 16b. Kind of Business/Industry<br><b>MANUFACTURING</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ALBERT EDWIN DEEMER</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILA HOPKINS</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY H. DEEMER/WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22215 RED LION BRANCH ROAD, MILLINGTON, MD 21651</b>   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>03/03/2007 STEVENSVILLE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>FELLOW, HELFENBEIN AND NEWNAM FUNERAL HOME, PA<br/>130 SPEER ROAD, CHESTERTOWN, MD 21620</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CORONARY ARTERY DISEASE</b>   |  | 23b. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify) |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 26. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 27a. Date of Injury (Month, Day Year)  |  | 27b. Time of Injury<br><b>M</b>   |  |
| 27c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 27d. Describe how injury occurred  |  |   |  |
| 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 27f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 28a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28b. Signature and title of certifier<br>  |  |   |  |
| 28c. License number<br><b>D0041587</b>   |  | 28d. Date signed (Month, Day, Year)<br><b>3/2/2007</b>   |  |   |  |
| 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HELEN NOBLE MD 122 SPEER RD CHESTERTOWN MD 21620</b>  |  |  |  |   |  |
| 30. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>  |  | 31. Registrar's Signature<br>  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08375

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JACK DUBOSE</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>27</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>18:58</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>  |  | 4c. County of Death<br><b>PRINCE GEORGE</b>  |  |
| 5. Social Security Number<br><b>579-46-3908</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>70</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>JUNE 4, 1936</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGE</b>   |  | 10c. City, Town or Location<br><b>SUITLAND</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3804 SWANN RD</b>  |  | 10f. Zip Code<br><b>20746</b>  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>   |  | 16b. Kind of Business/Industry<br><b>PRIVATE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JACK DUBOSE SR</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE TENNEN</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PEGGY DUBOSE/WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3804 SWANN RD SUITLAND, MD 20746</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>03-06-2007 LANDOVER, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>K. D. H. Hall</b>   |  | 22. Name and Address of Facility<br><b>JB JENKINS FUNERAL HOME</b><br><b>7474 LANDOVER RD LANDOVER, MD 20785</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. CORONARY BY-PASS GRAFT</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>METASTATIC PROSTATE CANCER</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dr. Anil K. Mahajan MD</b>   |  |
| 29c. License number<br><b>D50689</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02/27/2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANIL K. MAHAJAN MD</b><br><b>SOUTHERN MARYLAND HOSPITAL CENTER, 7503 SURREATERS RD CLINTON MD 20735</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  | 32. Registrar's Signature<br><b>Sam S. [Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar Amend #5 Per Inf G865 3/22/07  
 Certificate of Death

Reg. No.

2007 08376

|   |   |   |   |  |   |   |  |  |   |
|---|---|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Paula Spence David</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 27 2007</b>   |   | 3. Time of Death<br><b>10:00A M</b>  |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>303 Switchgrass Court</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Upper Marlboro</b>   |   | 4c. County of Death<br><b>Prince George's</b>                                      |  |   |
| Funeral<br>Director   | 5. Social Security<br><b>3578 579-82-3570</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 13, 1965</b>                        |  |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Jamaica</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Upper Marlboro</b>                               |  |   |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  | 10e. Street and Number<br><b>303 Switchgrass Court</b>  |   |  |  |   |
|   | 10f. Zip Code<br><b>20774</b>   |   |   |  | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b> |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Agent</b>                 |  | 16b. Kind of Business/Industry<br><b>Private</b>  |   |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Aston Leonard Spence</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olive VanHorne</b>  |   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anselm B. David/Husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>303 Switchgrass Ct., Upper Marlboro, MD 20774</b>   |   |  |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakemont Cemetery</b>  |  | 20c. Date<br><b>3/6/2007</b>  |   | 20d. Location - City or Town, State<br><b>Davidsonville, MD</b>                    |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |   |   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home<br/>4001 Benning Rd., NE Wash., DC 20019</b>  |   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Colon Cancer</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  | Approximate Interval Between Onset and Death  |   |  |  |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown   |   |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |
| 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Divya Verma M.D.</b>  |   |   |   | 29c. License number<br><b>D52298</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 2, 2007</b>   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Divya Verma, M.D. 7525 Greenway Ctr. Dr., #202 Greenbelt, MD 20770</b>   |   |   |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |   |   |   | 32. Registrar's Signature<br><b>David B. Spence</b>                          |   |   |  |  |   |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08377

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Michele Elaine Dotson

2. Date of Death

Month Day Year  
March 5, 2007

3. Time of Death

1032 hrs

4a. Facility Name (If not institution, give street and number)

Easton Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

199-54-9332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

04-14-1971

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Ridgley

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12050 School St. Apt #7

10f. Zip Code

21660

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed (Computer)

16b. Kind of Business/Industry

Scent Sensations

17. Father's Name (First, Middle, Last)

Linwood R. Dotson

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Joyce Gwynn

19a. Informant's Name/Relationship (Type, Print)

Linwood R. Dotson / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1630 S. Conestogo St. Philadelphia PA 19943

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cokers Cemetery

Date

3/14/07

20c. Location - City or Town, State

Greensboro, MD

21. Signature of Funeral Service Licensee

Hammie L. Shaw

22. Name and Address of Facility

Bennie Smith Funeral Home

426 E. Dover St. Easton MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, per ME, g866, 4/21/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Melissa Brassell, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 6, 2007

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 13 2007

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Physician/  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08378

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Joseph Dreszer

2. Date of Death  
Month Day Year  
February 28, 20073. Time of Death  
6:50 A M

4a. Facility Name (If not institution, give street and number)

Calvert County Nursing Center

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert County

5. Social Security Number

380-24-8070

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 14, 1928

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert County

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 Walnut Creek Road

10f. Zip Code

20639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lab Technician

16b. Kind of Business/Industry

Film Company

17. Father's Name (First, Middle, Last)

Rudolph Dreszer

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bucholz

19a. Informant's Name/Relationship (Type, Print)

Mark Dreszer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Walnut Creek Road, Huntingtown, Maryland 20639

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

March 1, 2007

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Home Licensee

Michael W. Lee

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.  
8125 Southern Maryland Blvd., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

CAD

atrial Fibrillation

Pneumonia

Aneurysm

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Shal MD

29c. License number

D 50290

29d. Date signed (Month, Day, Year)

2-28-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dreszer Shal 110, Hosp RD Prince Fred MD 20638

31. Date filed (Month, Day, Year)

MAR 2 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08379

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DARRYL EVANS

2. Date of Death

MAR 03 07

3. Time of Death

2:50 P M

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

244-21-5317

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/8/1963

9. Birthplace (State or Foreign Country)

CAROLINA  
NASH, NORTH

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

JESSUP

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8450 DORSEY RUN ROAD

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CATERER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

WILLIAMS EVANS

18. Mother's Name (First, Middle, Maiden Surname)

GWENDOLYN BROWN

19a. Informant's Name/Relationship (Type. Print)

PEGGY EVANS/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

818 GOLD ST ROCKY MOUNT N.C. 27804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Church Cemetery

Date

3/7/2007

20c. Location - City or Town, State

ROCKY MOUNTIAN N.C.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPTIC SHOCK

Approximate Interval Between Onset and Death

24 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

HSV ENCEPHALITIS

3 WEEKS

b. Due to (or as a consequence of):

ACQUIRED IMMUNE DEFICIENCY SYNDROME 13 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA,

ACUTE RENAL FAILURE

ANEMIA OF CHRONIC DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Juan A. Cabrera, M.D.

29c. License number

D64220

29d. Date signed (Month, Day, Year)

MAR. 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5755 CEDAR LANE, COLUMBIA, MD 21044 / JUAN CABRERA, M.D.

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State  
Registrar

19a.

WCHD/SC

FH/3-9-07

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08380

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Imogene Victoria Edwards

2. Date of Death

Month Day Year  
MARCH 4 2007

3. Time of Death

5:20p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

217-42-9231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10/26/1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

344 Coneflower Drive

10f. Zip Code

21795

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Convenience Store

17. Father's Name (First, Middle, Last)

Chester Vernon Mills

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Lorraine Shives

19a. Informant's Name/Relationship (Type, Print)

Robert V. Graves / Son  
Edwards

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5124 Lincolnway West, St. Thomas, PA 17252

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

03/08/2007

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich Funeral Home

305 N. Potomac Street, Hagerstown, MD 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Approximate Interval Between Onset and Death

4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

4 weeks

c. Chronic obstructive lung disease

years

d. Morbid Obesity

-

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Chronic leg Cellulitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (If not a) (Type, Print)

Zafar Malik MD, 20311 Lappans Rd Boonsboro MD 21713

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08381

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN EVERSOLE

2. Date of Death

Month

Day

Year

03

04

07

3. Time of Death

0154M

4a. Facility Name (If not institution, give street and number)

HOMWOOD RETIREMENT CENTER

4b. City, Town, or Location of Death

WILLIAMSPORT MD

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

214-09-4798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 27 1911

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16505 Virginia Avenue

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

Robert George Frye

18. Mother's Name (First, Middle, Maiden Surname)

Alice Gladys Hickman

19a. Informant's Name/Relationship (Type, Print)

Eugene Frye - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

167 Drewery Lane Falling Waters, W. Va. 25419

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

3/8/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Robert George Frye

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

SEVERAL YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DEGENERATIVE JOINT DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

K. Strauss MD

29c. License number

047234

29d. Date signed (Month, Day, Year)

03/04/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KELLI STRAUSS MD 13424 PENNSYLVANIA AVE HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Kelli Strauss

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08382

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Angess Rebecca Ezelle

2. Date of Death

Month Day Year  
March 1 2007

3. Time of Death

3:15 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

217-28-8373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

Oct. 16 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

405 Bowie Shop Road

10f. Zip Code

20639

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Deli manager

16b. Kind of Business/Industry

grocery store

17. Father's Name (First, Middle, Last)

James Maude Armiger

18. Mother's Name (First, Middle, Maiden Surname)

Lovette I Mister

19a. Informant's Name/Relationship (Type, Print)

George L. Ezelle, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

405 Bowie Shop Road, Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Southern Mem. Grdns.

Date

03-05-2007

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, PA Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Septic Shock

Sequentially list conditions, if any, which caused the death. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

Infected Decubitus Ulcer

b.

Due to (or as a consequence of):

Urinary Tract Infection

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Renal Failure

Rheumatoid Arthritis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33123

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, M.D. 110 Hospital Road, Suite 310, Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

MAR 5 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08383

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eva Fulmer

2. Date of Death

Month Day Year  
3/8/2007

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

Julia Manor Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

216-76-5136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/12/1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

241 South Prospect Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Charles J. Fulmer

18. Mother's Name (First, Middle, Maiden Surname)

Dora Toms

19a. Informant's Name/Relationship (Type, Print)

Vanessa Smith Great Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8502 Rosebud Ct Middletown, MD 21769

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crem.

Date

3/10/2007

20c. Location - City or Town, State

Smithsburg, MD

21. Signature of Funeral Service Licensee

M01176

22. Name and Address of Facility Keeney &amp; Basford P.A. F.H.

106 East Church St. Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30x

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia  
Due to (or as a consequence of):

20x

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

052323

29d. Date signed (Month, Day, Year)

03-09-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Murshed M.D. 1126 Opal Ct. Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death


Reg. No.

1- For State Registrar

Physician /Medical Examiner


Funeral Director

To Be Completed by Funeral Director

|   |  |   |  |  |                           |   |   |  |   |
|---|--|---|--|--|---------------------------|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Eloise Forrest</b>   |  |   |  |  |                           | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>2007</b>    |   | 3. Time of Death<br><b>9:45 P<sup>M</sup></b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Wilson Health Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>  |                           | 4c. County of Death<br><b>Montgomery</b>                                |   |  |   |
| 5. Social Security Number<br><b>131-09-2811</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>89</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours | If Under 24 Hrs.<br>Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 24, 1917</b>            |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |
| Usual Residence of Decedent   |  |   |  |  |                           |   |   |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>   |                           |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>19309 Cypress Hill Way</b>   |  |   |  | 10f. Zip Code<br><b>20879</b>  |                           | 10g. Citizen of What Country?<br><b>United States</b>                   |   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                           |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner / Operator</b>   |                           |   | 16b. Kind of Business/Industry<br><b>Grocery</b>                        |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Blanchard Newton</b>  |  |   |  |  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Taylor</b> |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Woodrow Wilson Forrest Jr./Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19309 Cypress Hill Way, Gaithersburg, MD 20879</b>                                       |                           |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Person Memorial</b>  |  | Date<br><b>March 14 2007</b>   |                           | 20c. Location - City or Town, State<br><b>Roxboro, North Carolina</b>   |   |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</b>   |                           |   |   |  |   |

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |                                      |  |  |  |   |  |   |  |  |  |   |  |                                   |  |
|---|--|---|--|--|--|--------------------------------------|--|--|--|---|--|---|--|--|--|---|--|-----------------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pulmonary Fibrosis</b><br>Due to (or as a consequence of):<br><b>Rheumatoid Arthritis</b><br>Due to (or as a consequence of):<br><b>Vascular Dementia, Hypertension</b><br>Due to (or as a consequence of): |  |   |  |  |  |                                      |  |  |  | Approximate Interval Between Onset and Death<br>Years   |  |   |  |  |  |   |  |                                   |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |  |                                      |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                    |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Vascular Dementia, Hypertension</b>  |  |   |  |  |  |                                      |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |                                      |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D41794</b> |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>March 8, 2007</b>   |  |   |  |  |  |   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Priscilla Callahan-Lyon M.D., 911 Russell Avenue, Gaithersburg, MD 20879</b>   |  |   |  |  |  |                                      |  |  |  |   |  |   |  |  |  |   |  |                                   |  |

State Registrar

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b> | 32. Registrar's Signature<br> |
|---|--|

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08385

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HOBART MARVIN FRIAR</b>                       |   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>2</b> Year <b>2007</b> |   | 3. Time of Death<br><b>6:20 PM</b>                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtwn</b>            |   | 4c. County of Death<br><b>St. Mary's</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>305-24-7360</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>09/26/1927</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>                                   |   | 10a. State<br><b>Indiana</b>   |  | 10b. County<br><b>Delaware</b>                                       |   | 10c. City, Town or Location<br><b>Muncie</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>4501 North Wheeling Avenue 7B-102</b>  |  | 10f. Zip Code<br><b>47304</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retail Salesman</b>               |  | 16b. Kind of Business/Industry<br><b>Clothing</b>  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hobart Mckinley Friar</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumame)<br><b>Laone Marguett Rife</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joette Ruddick/ Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22061 St. Elizabeth Court, Great Mills, MD 20634</b>                                     |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols Cr.</b>  |  | 20c. Location - City or Town, State<br><b>03-05-2007 Charlotte Hall, MD</b>  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Kyle S. Simons M01206</b>   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, Maryland 20650</b>                    |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sephic Shock</b>   |  |   |  |  |  |   |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Patient Energy malnutrition</b><br><b>Anemia</b>  |  |   |  |  |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |
| 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |  | 29c. License number<br><b>D61719</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 3, 2007</b>                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DHANANJAY V BHAVSAR HOLLYWOOD MARYLAND 20636</b>   |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

HOBERT MARVIN FRIAR

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08386

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| Physician/<br>Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DOUGLAS WAYNE FLOWERS</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>5</b> Year <b>2007</b>   |   | 3. Time of Death<br><b>1539 hrs</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>205 Ellicott Drive</b>   |  | 4b. City, Town, or Location of Death<br><b>Chester</b>   |   | 4c. County of Death<br><b>Queen Anne's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>222-50-8447</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>08/04/1968</b>  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |   |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |   |   |
|   | 10a. State<br><b>MD</b>   | 10b. County<br><b>QUEEN ANNE'S</b>   | 10c. City, Town or Location<br><b>CHESTER</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>205 ELLICOTT DRIVE</b>   |  | 10f. Zip Code<br><b>21619</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |
|   | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |   |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISABLED</b>  |  | 16b. Kind of Business/Industry   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>MORGAN FLOWERS, JR.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SUSAN REBECCA POWELL</b>   |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SUSAN R. FLOWERS/MOTHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>209 CRANE STREET, MILLINGTON, MD 21651</b>   |   |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MILLINGTON ASBURY</b>   |   | 20c. Location - City or Town, State<br><b>03/11/2007 MILLINGTON, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA<br/>130 SPEER ROAD, CHESTERTOWN, MD 21620</b>   |   |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Mixed drug intoxication (cocaine and methadone)</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED <b>#25a, 27, 28a-f, per ME, g865, 3/23/07 TT</b> |  |  |   | Approximate Interval Between Onset and Death  |
|   | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
|   | 23d. Date of delivery<br>Month Day Year   |  |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |   |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Fnd 3/5/2007</b>  |   |   |
|   | 28b. Time of Injury<br><b>Fnd 3:28 pm</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |
|   | 28d. Describe how injury occurred<br><b>unk</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found in residence</b>   |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>205 Ellicott Dr. Chester, MD</b> |   |  |  |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Melissa Brassell, MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 6, 2007</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |  |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 07 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |   |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08387

1- For  
State  
Registrar

|   |   |   |  |   |  |  |   |  |
|---|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marguerite B. Fogarty</b>  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>4</b> , Year <b>2007</b>   |  | 3. Time of Death<br><b>8:25 P M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10208 Fox Ridge Drive</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Damascus</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-32-0122</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 3, 1909</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maine</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Damascus</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 10e. Street and Number<br><b>10208 Fox Ridge Drive</b>   |  | 10f. Zip Code<br><b>20872</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)                            |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personnel Assistant</b>   |   |  |   | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Leon Bourbeau</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gratia Morin</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Michael Fogarty - Son</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10208 Fox Ridge Drive, Damascus, Maryland 20872</b>                                |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven</b>  |   | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>  |  | 20d. Date<br><b>3/08/07</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>  |   |  |   | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>myocardial infarction</b><br>a. Due to (or as a consequence of):<br><b>Coronary artery disease</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |  |   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's disease</b><br><b>CHTN</b> |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>29b. Signature and title of certifier<br><b>NAAZ A Hussain</b>   |   |   |  |   |  |  |   |  |
| 29c. License number<br><b>D46861</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/5/07</b>  |  |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NAAZ A. HUSSAIN 195 T.J. Drive Frederick, Md 21702</b>                   |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |   | 32. Registrar's Signature<br><b>Robert L. Williams</b>  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00388

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley M. Finney

2. Date of Death

Month Day Year  
02 24 07

3. Time of Death

07:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1210 Market Street Apt. D3

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

214-76-8894

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8-2-38

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1210 Market Street Apt. D3

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ann Finney

19a. Informant's Name/Relationship (Type, Print)

Margaret Ann McRay (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 N. New York Ave. Atlantic City, N.J. 08401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delaware

Date

3-3-07

20c. Location - City, Town, State

Delmar De.

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

Bernie Smith Funeral Home

P.O. Box 331 Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute coronary syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D24871

29d. Date signed (Month, Day, Year)

3/01/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY L Finney 305 10th Street, Pocomoke MD 21851

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BA 4

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08389

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Frederick Fairhurst

2. Date of Death  
Month Day Year

March 1, 2007

3. Time of Death

1:50 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

020-16-3941

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 2, 1918

9. Birthplace (State or Foreign  
Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

604 Marshall Court

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Business Machines

17. Father's Name (First, Middle, Last)

George Willard Fairhurst

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Rachel Hayes

19a. Informant's Name/Relationship (Type, Print)

Donna R. Gryn - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 Marshall Court, Waldorf, MD 20602

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Huntt Crematory

Date

3-3-2007

20c. Location - City or Town, State

Waldorf, MD

21. Signature of Funeral Service Licensee

M00053

22. Name and Address of Facility

3035 Old Washington Road  
Huntt Funeral Home Waldorf, MD 2060123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONCUSSION SYNDROME

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D006h801

29d. Date signed (Month, Day, Year)

3/2/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhann Patel M.D., 7501 Surratts Rd., Suite 307, Clinton, MD 20735

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Bhann Patel

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08390

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jessie Reynolds Gran</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 28, 2007</b>  |  | 3. Time of Death<br><b>12:55 a M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>8918 Harmony Court</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Owings</b>   |  | 4c. County of Death<br><b>Calvert</b>  |  |
| 5. Social Security Number<br><b>409-26-4943</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1919</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>  |  |   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  |   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Owings</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |
| 10e. Street and Number<br><b>8918 Harmony Court</b>   |  |   |  | 10f. Zip Code<br><b>20736</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>congressional assistant</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>David Reynolds</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nell Trammel</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William S. Gran, Jr., son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7237 Deer Lake Lane, Derwood, MD 20855</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>So. Memorial Gardens</b>   |  | Date<br><b>03/05/07</b>   |  | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>8325 Mt. Harmony Lane, Owings, MD 20736</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>metastatic non-small cell lung cancer (skeletal metastases)</b><br>Due to (or as a consequence of):<br>b. <b>non-small cell lung cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>5 months</b><br><b>19 months</b>   |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |   |  | 29c. License number<br><b>D56024</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 28 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kenneth L. Abbott 110 Hospital Road Suite 110 Prince Frederick MD 20678</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 5 2007</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ID

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08391

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT EZEKIEL GREEN

2. Date of Death

February 27, 2007

3. Time of Death

7:40 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

247-70-3405

6. Sex

152 M 20 F

7. Age (in yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/18/1942

9. Birthplace (State or Foreign Country)

Sumter S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

10614 Cedarwood Lane

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No  
If Yes, Give Year or Dates: 64-70

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grid Caster

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Julius Green

18. Mother's Name (First, Middle, Maiden Surname)

Angeline Major

19a. Informant's Name/Relationship (Type, Print)

Bessie Green - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10614 Cedarwood Lane Ft. Washington MD 20744

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Cheltenham Vet. Cem.

Date

03/06/2007

20c. Location - City or Town, State

Cheltenham Maryland

21. Signature of Funeral Service Licensee

Staylor

22. Name and Address of Facility

Pope Funeral Home  
5538 Marlboro Pike Forestville Maryland 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
10 Yes 20 No  
90 Unknown

23c. If yes, outcome of pregnancy

10 Live birth 20 Fetal death  
40 Pregnant at time of death 50 Other (specify)  
90 Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus  
End Stage Renal Failure

23e. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?  
10 Yes 20 No24b. Were autopsy findings available prior to completion of cause of death?  
10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Singh

29c. License number

D45660

29d. Date signed (Month, Day, Year)

2-28-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dpinder Singh, M.D.

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

B. Singh

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08392

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Luke Christopher Hannon

2. Date of Death

Month Day Year  
2 22 2007

3. Time of Death

3:50a M

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

102-22-8323

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6 27 1930

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Harpoon RD

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Luke Joseph Hannon

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Thomas

19a. Informant's Name/Relationship (Type, Print)

Marie Hannon (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Harpoon RD, Berlin, MD 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crem.

Date

2/26/2007

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home

108 William St., Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

un known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 48130

29d. Date signed (Month, Day, Year)

3/5/07

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Jeffrey Thomas Greenwood 9733 Heathway Drive Berlin MD 21811

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, per PHYS. G865, 3/19/07 WS  
State of Maryland / Department of Health and Mental Hygiene1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2007 08393

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Herbert Hoover

2. Date of Death

Month Day Year  
March 5, 2007

3. Time of Death

1:40 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

901 Bernoudy Road

4b. City, Town, or Location of Death

White Hall

4c. County of Death

Baltimore

5. Social Security Number

219-28-4725

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 20, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

901 Bernoudy Road

10f. Zip Code

21161

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Baltimore County  
Schools

17. Father's Name (First, Middle, Last)

Benjamin H. Hoover

18. Mother's Name (First, Middle, Maiden Surname)

Edna Frey

19a. Informant's Name/Relationship (Type, Print)

Sallye A. Hoover, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Bernoudy Rd., White Hall, MD 21161

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mountville Cemetery

Date

March 9,  
2007

20c. Location - City or Town, State

Mountville, PA

21. Signature of Funeral Service Licensee

Michael W. Korman

22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc.

24 Second St., New Freedom, PA 17349

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Philip M. Mitello MD Deputy

29c. License number

D18667

29d. Date signed (Month, Day, Year)

March 6, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip M. Mitello MD 6 Trimble Hill Ct. Lutherville, MD 21093

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21206

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08394

1- For  
State  
Registrar

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph D. Hurst</b>  |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>4:25A M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Rockville Nursing Home</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>159-12-5299</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 5, 1913</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Germantown</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>22700 Ridge Road</b>  |  | 10f. Zip Code<br><b>20876</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Estimator</b>                                |  | 16b. Kind of Business/Industry<br><b>Heating &amp; Air Conditioning</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William Lloyd Hurst</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Couchenour</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda New - Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22700 Ridge Road, Germantown, Maryland 20876</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Irwin Union Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Irwin, Pennsylvania</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>  |  | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>dementia</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>years</b> |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br><b>Steven Dolinsky</b>   |  | 29c. License number<br><b>D-20148</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 2, 2007</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Steven Dolinsky, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879</b>  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  | 32. Registrar's Signature<br><b>Steven B. Sparks</b>   |  | 33. Date of Death<br><b>March 2, 2007</b>   |  | 34. Time of Death<br><b>4:25A M</b>  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 08395

1- For State Registrar

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 44  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Paul William Johnson Jr.</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>1:11 A. M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>22418 Old Georgetown Rd. P.O. Box 1</b>   |  | 4b. City, Town, or Location of Death<br><b>Cavetown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>219-20-1031</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>March 2, 1925</b>                        | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Md.</b>   | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Cavetown</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>22418 Old Georgetown Rd. P.O. Box 1</b>   |  | 10f. Zip Code<br><b>21720</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>42-52</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver</b>  |  | 16b. Kind of Business/Industry<br><b>Truck</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Paul W. Johnson Sr.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret A. Leatherman</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Violet E. Johnson (Wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22418 Old Georgetown Rd. P.O. Box 1 Cavetown, Md. 21720</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Hagerstown, Md.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>J. L. Davis</b>  |  | 22. Name and Address of Facility<br><b>12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Prostate Cancer</b><br>Due to (or as a consequence of):<br><b>b. Atrial Fibrillation</b><br>Due to (or as a consequence of):<br><b>c. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  | Approximate Interval Between Onset and Death   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Vincent A. Cantone</b>   |  | 29c. License number<br><b>D0050362 MD</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/12/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vincent A. Cantone M.D. 22911 Jefferson Blvd. Smithsburg, Md. 21783</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>  |  | 32. Registrar's Signature<br><b>J. L. Davis</b>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items 23b, d, f per ME, g865, 03/19/07 28b

Reg. No. 2007 08396

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kevin Paul Janowsky</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>27</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>6:19 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>44717 Smith Nursery Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Hollywood</b>  |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| 5. Social Security Number<br><b>366-52-8977</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>January 15, 1951</b> | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Hollywood</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>44717 Smith Nursery Road</b>   |  | 10f. Zip Code<br><b>20636</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Government Contractor</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Russell Janowsky</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Hamann</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Imogene Abbott / Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44717 Smith Nursery Road, Hollywood, Maryland 20636</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico National Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Triangle, Virginia</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael R. Gardiner</i>   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.</b><br><b>P.O. Box 270, Leonardtown, Maryland 20650</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Asphyxia CARBONICA.</b><br>Due to (or as a consequence of):<br><br>b. <b>Suicide</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |  | 23d. Date of delivery<br>Month Day Year  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br><b>2-27-07</b>   |  | 28b. Time of Injury<br><b>4:00 PM</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Asphyxiation</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>44717 Smith Nursery Rd. Hollywood MD</b>  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>William D. Boyd, II, M.D.</i>   |  | 29c. License number<br><b>014245</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>3-1-07</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William D. Boyd, II, M.D.</b><br><b>25365 Point Lookout Road, Leonardtown, Maryland 20650</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 02 2007</b>  |  |
| 32. Registrar's Signature<br><i>Erin B. Spiller</i>   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08397

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen JONES

2. Date of Death

Month

Day

Year

March

4

2007

3. Time of Death

7:31p.m.

4a. Facility Name (If not institution, give street and number)

147 S. Mulberry Street

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

218-52-5685

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 4, 1930

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

147 S. Mulberry Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurses Assistant

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Granada Fouke - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Frederick Street, Hagerstown, Md. 21740

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Lawn Mem. Park 3/8/07

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Fred L. Venter

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

56 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hind Hamdan MD

29c. License number

D46473

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 1130 OPAL CT.; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Brian S. Spelt

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08398

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Marie Kimble

2. Date of Death  
Month Day Year

February 27, 2007

3. Time of Death  
Month Day Year

5:07 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Marley Neck Health &amp; Rehab Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

278-34-2093

6. Sex  
1 ☐ M 2 ☒ F

X

7. Age (In yrs. last birthday)

69

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

November 27, 1937

9. Birthplace (State or Foreign  
Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicville

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

39433 Summit Hill Drive

10f. Zip Code

20659

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Security

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Anne T. Heikkila

19a. Informant's Name/Relationship (Type, Print)

William Kimble/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39433 Summit Hill Drive, Mechanicville, MD 20659

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Brinsfield-Echols Crem.

Date

March 2,  
2007

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

William Kimble

22. Name and Address of Facility

Brinsfield-Echols F.H., P.A.,  
30195 Three Notch Rd., Charlotte Hall, MD 2062223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
Cardiac ArrhythmiaSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Failure to thrive  
Gastric Stasis Reversal Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ COA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aditya Chopra MD

29c. License number

D57028

29d. Date signed (Month, Day, Year)

2-28-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aditya Chopra MD 600 Ridgely Ave #231 Annapolis MD 21401

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Linda Marie Kimble

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08399

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELGA KRAEMER

2. Date of Death

MARCH 2 2007

3. Time of Death

4:57 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

22680 CEDAR LANE NUMBER 1329

4b. City, Town, or Location of Death

LEONARDTOWN

4c. County of Death

ST. MARY'S

5. Social Security Number

577-44-4984

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

MARCH 4, 1920

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

ST. MARY'S

10c. City, Town or Location

LEONARDTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22680 CEDAR LANE NUMBER 1329

10f. Zip Code

20650

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RETAIL CLERK

16b. Kind of Business/Industry

GIFT STORE

17. Father's Name (First, Middle, Last)

(UNAVAILABLE)

18. Mother's Name (First, Middle, Maiden Surname)

(UNAVAILABLE)

19a. Informant's Name/Relationship (Type, Print)

NICOLE C. BELKOV / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4301 HUMBOLT COURT WALDOKE, MARYLAND 20601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BRINSFIELD-ECHOLS CR.

Date

MARCH 5, 2007

20c. Location - City or Town, State

CHARLOTTE HALL, MD

21. Signature of Funeral Service Licensee



MO0641

22. Name and Address of Facility

BRINSFIELD-ECHOLS FUNERAL HOME, P.A.

30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer (Metastatic)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 47066

29d. Date signed (Month, Day, Year)

3-5-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avani D. Shah, M.D., 22650 Cedar Lane Court, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature



Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08400

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Michael Koehler

2. Date of Death

Month Day Year  
March 5, 2007

3. Time of Death

1:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

17488 River Drive

4b. City, Town, or Location of Death

Piney Point

4c. County of Death

St. Mary's

5. Social Security Number

137-20-4635

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 28, 1927

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Piney Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17488 River Drive

10f. Zip Code

20674

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Supply Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Emil Koehler

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Walther

19a. Informant's Name/Relationship (Type, Print)

Charlene Koehler Forrest / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1000, Solomons, Maryland 20688

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. George's Catholic

Cemetery

Date

March

9, 2007

20c. Location - City or Town, State

Valley Lee, Maryland

21. Signature of Funeral Service Licensee

*Michael R. Gardiner*

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Multiple intracerebral metastases*

Due to (or as a consequence of):

b. *Small cell carcinoma of left lung.*

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate Interval Between Onset and Death

1 Month

9<sup>th</sup> month 2007

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*John W. Roache*

29c. License number

D15027

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W. Roache, M.D. P.O. Box 186, Mechanicsville, Maryland 20659

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

*John W. Roache*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08401

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leroy Knox

2. Date of Death

February 27 2007

3. Time of Death

1530 M

4a. Facility Name (If not institution, give street and number)

2317 Bentonia Court

4b. City, Town, or Location of Death

District Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

241-66-6061

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 20, 1944

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

District Heights

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2317 Bentonia Court

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mail Handler

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Will Armstrong

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Knox

19a. Informant's Name/Relationship (Type, Print)

Kieca Cole/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10432 Sextant Place, White Plains, MD 20695

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pleasant Grove Bapt. Ch. Cem.

Date

3/7/2007

20c. Location - City or Town, State

Bowling Green, SC

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., NE Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions,  
if any leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No

9 Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending  
investigation☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hema P. Yadla, M.D.

29c. License number

D0060546

29d. Date signed (Month, Day, Year)

3/02/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hema P. Yadla, M.D. 9470 Annapolis Road, Suite #315, Lanham, MD 20706

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Brenda S. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08402

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                 |  |
|---|---|--|---|---|--|---------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Susan Marie King  |  |   | 2. Date of Death<br>Month Day Year<br>March 5, 2007 |  | 3. Time of Death<br>9:00 A M    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Beverly Living Ctr. of Cumberland   |  |   | 4b. City, Town, or Location of Death<br>Cumberland  |  | 4c. County of Death<br>Allegany |  |
| Funeral<br>Director                           | 5. Social Security Number<br>211-12-8960  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>90 Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br>04/02/1916                |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  | 10a. State<br>MD  |   | 10b. County<br>Allegany  |                                 | 10c. City, Town or Location<br>Cumberland                        |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>941 Bishop Walsh Drive, Apt 2   |   | 10f. Zip Code<br>21502   |                                 | 10g. Citizen of What Country?<br>USA                             |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   | 16b. Kind of Business/Industry<br>Home   |                                 |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Horevay   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan Grexa  |   | 19a. Informant's Name/Relationship (Type, Print)<br>Marlene S. Taylor / daughter   |                                 |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Route 2 Box 209, Keyser, WV 26726  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunset Memorial Park   |                                 | 20c. Location - City or Town, State<br>Cumberland, MD            |
|   | 21. Signature of Funeral Service Licensee<br>Robert C. Adams  |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of): Cerebrovascular accident<br>b. Due to (or as a consequence of): Cardiomyopathy - ischaemic.<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>months.<br>years. |                                 |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year  |                                 |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                 |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |                                 |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                 |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                 |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Peter Halmos MD  |   | 29c. License number<br>DO 4981   |                                 | 29d. Date signed (Month, Day, Year)<br>March 5, 2007             |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PETER HALMOS 10000 Carrington Court, Cumberland, Md 21502   |  | 31. Date filed (Month, Day, Year)<br>MAR 06 2007  |   | 32. Registrar's Signature<br>[Signature]   |                                 |  |
|   | 33. State Registrar   |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036   |   |  |                                 |  |

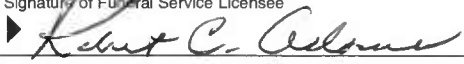


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08403

1- For  
State  
Registrar

|  |   |  |   |  |   |  |  |   |  |  |
|--|---|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>lois kershaw</b>   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 02, 2007</b>  |   | 3. Time of Death<br><b>0949 M</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>WMHS-Memorial Campus</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>                       |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>151-50-6921</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>08/14/1956</b>     |   | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>                                  |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>WV</b>   |  | 10b. County<br><b>Morgan</b>  |  | 10c. City, Town or Location<br><b>Paw Paw</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>192 Elise Lane</b>   |  |   |  | 10f. Zip Code<br><b>25434</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Home</b>                           |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Burton Robinson, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Arlene Bailey</b>   |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Earl Kershaw / husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>192 Elise Lane, Paw Paw, WV 25434</b>   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cumberland Crematory</b>   |  | Date<br><b>03/03/2007</b>   |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Adams Family Funeral Home, P.A.<br/>404 Decatur Street, Cumberland, MD 21502</b>   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |   |  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizure</b><br><b>Lactic Acidosis</b><br><b>Acute Renal Failure</b><br>23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br>26. Place of Death (Check only one)<br>27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br><b>M</b><br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>29b. Signature and title of certifier<br> <b>M.D.</b><br>29c. License number<br><b>D63118</b><br>29d. Date signed (Month, Day, Year)<br><b>MARCH 02, 2007</b>  |   |  |   |  |   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wiraset Hasnain M.D. 900 Seton Drive Cumberland, MD. 21502</b>  |   |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b><br>32. Registrar's Signature<br>  |   |  |   |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 Per M 6865 3/20/07  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No. 2007 08404

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Stella Koslosky</b>  |   | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>4:39 P<sup>M</sup></b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10509 Marlowe Lane</b>   |   | 4b. City, Town, or Location of Death<br><b>Ocean City</b>  |  | 4c. County of Death<br><b>Worcester</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>191-28-2222</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 25, 1936</b>   | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>   |
|   | Usual Residence of Decedent   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Worcester</b>   | 10c. City, Town or Location<br><b>Ocean City</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>10509 Marlowe Lane</b>   |   | 10f. Zip Code<br><b>21842</b>  |  | 10g. Citizen of What Country?<br><b>US</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>4+</b> |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>   |   | 16b. Kind of Business/Industry<br><b>Hospital</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Michael Bussacca</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Oliver</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John T. Koslosky</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10509 Marlowe Lane, Ocean City, Md. 21842</b>  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crem.</b>   |  | 20c. Location - City or Town, State<br><b>Frankford, DE</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Kim MacLeod</i>   |   | 22. Name and Address of Facility<br><b>The Burbage Funeral Home<br/>108 William St., Berlin, Md. 21811</b>   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiovascular Dx</b><br>Due to (or as a consequence of):<br>b. <b>Cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Copd/Emphysema</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, only, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Jeffery Maturi MD</i>   |   | 29c. License number<br><b>H0053714</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/1/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeffery Maturi MD 314 Franklin Ave Suite 302 Berlin MD 21811</b>   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |   | 32. Registrar's Signature<br><i>Brian H. Smith</i>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08405

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY M. LYNCH

2. Date of Death

Month FEB. Day 27 Year 2007

3. Time of Death

7:00 P M

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

219-12-4377

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 25, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37544 SALTY WAY DRIVE

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

THOMAS E. VonGARLEM

18. Mother's Name (First, Middle, Maiden Surname)

LULA C. DAVIS

19a. Informant's Name/Relationship (Type, Print)

JAMES R. LYNCH/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37544 SALTY WAY DRIVE, SELBYVILLE, DE. 19975

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CREMATORY OF DELMARVA

Date

3/1/07

20c. Location - City or Town, State

DELMAR, DELAWARE

21. Signature of Funeral Service Licensee

V. Byrnes B. Sp... MO1343

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. subarachnoid hemorrhage  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent stroke

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. van Edmond MD

29c. License number

D56307

29d. Date signed (Month, Day, Year)

2/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. van Edmond MD, Atlantic General Hospital, 9733 Healthway Drive, Berlin, MD 21811

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Dennis H. Spauld

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitLynch, Emily M. DOB: 5/25/12  
219-12-4377 DOB: 3/27/07 TOD: 1900  
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08406

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Roger Lee LINE Sr.

2. Date of Death

March 5, 2007

3. Time of Death

4:03 AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-42-1007

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 31 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18810 Eliason Way

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1967-70

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Lawn/Garden

17. Father's Name (First, Middle, Last)

John Henson Line

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Mae Campbell

19a. Informant's Name/Relationship (Type, Print)

Patricia Ann Line - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18810 Eliason Way, Hagerstown, Md. 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

3/5/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D21457

29d. Date signed (Month, Day, Year)

3-5-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL WAHEED MD - 1284 OAKHILL AVE. HAGERSTOWN. MD 21742

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08407

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Lee Moyers

2. Date of Death

Month Day Year  
2 27 2007

3. Time of Death

01:58 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

Wicomico

5. Social Security Number

235-54-5151

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

5/19/1934

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

900 Marble Court

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dental Hygienist

16b. Kind of Business/Industry

Denistry

17. Father's Name (First, Middle, Last)

John Wesley Holbert

18. Mother's Name (First, Middle, Maiden Surname)

Florence Agnes Ryan

19a. Informant's Name/Relationship (Type, Print)

James Edward Moyers/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 Marble Court, Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

3/1/07

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Kell K. Drury CFS

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Septic Shock  
Due to (or as a consequence of):b. Clostridium Difficile colitis  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sgt. M. O.

29c. License number

D0062916

29d. Date signed (Month, Day, Year)

Feb. 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Svetlana Gutierrez MD 1415 South Division St. Salisbury MD 21804

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

Kell K. Drury

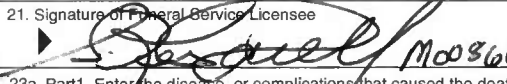


State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amended 3/5/07/item #10C/may Certificate of Death wic.dhnh Reg. No. 2007 08608

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Viola E. Megee</b>   |  | 2. Date of Death<br>Month Day Year<br><b>March 1 2007</b>  |  | 3. Time of Death<br><b>12:55 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Berlin Nursing &amp; Rehab Center, Inc.</b>  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>  |  | 4c. County of Death<br><b>Worcester</b>  |  |
| 5. Social Security Number<br><b>221-18-6958</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>March 12, 1920</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Worcester</b>  |  | 10c. City, Town or Location<br><b>Bishopville Berlin</b>   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>9715 Healthway Drive</b>  |  | 10f. Zip Code<br><b>21811</b>  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner / Operator</b>  |  | 16b. Kind of Business/Industry<br><b>Lawn Care Service</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Hickman</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella "Tubbs"</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Raymond Megee, Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12336 Back Creek Rd., Bishopville, MD 21813</b>  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Eastern Shore Crematorium</b>   |  | 20c. Location - City or Town, State<br><b>03/02/2007 Lewes, DE</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Parsell Funeral Homes &amp; Crematorium<br/>Rts. 26 &amp; 17, Clarksville, DE 19970</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>End Stage Dementia</b>   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  |
| 28b. Time of Injury<br><b>1</b> Yes 2 <input type="checkbox"/> No   |  | 28c. Describe how injury occurred  |  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 29b. Signature and Title of Certifier<br>  |  | 29c. License number<br><b>D 28769</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/2/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nicholas Borodulin, 1209 Coastal Highway, Fenwick Island, DE 19944</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>  |  | 32. Registrar's Signature<br>   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Megee, Viola E.  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division or Vital Records, P.O. Box 68760,

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08409

|   |   |  |  |   |  |  |  |
|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT A. MCKINNEY</b>   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>10<sup>th</sup></b> Year <b>2007</b>  |  | 3. Time of Death<br><b>5:29 PM</b>             |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNION HOSPITAL</b>   |  |  | 4b. City, Town, or Location of Death<br><b>ELKTON</b>   |  | 4c. County of Death<br><b>CECIL</b>            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>226-48-7091</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 3, 1938</b>                                     |
|   | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>  |  |  |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |   |  |  |  |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Cecil</b>  |   | 10c. City, Town or Location<br><b>Conowingo</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>965 Dr. Jack Road</b>  |  |  | 10f. Zip Code<br><b>21918</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Military</b>                                     |   | 16b. Kind of Business/Industry<br><b>U.S. Army</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James D. McKinney, Sr.</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Byrd</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. McKinney (Wife)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>965 Dr Jack Rd. Conowingo, MD 21918</b> |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co.</b>  |   | Date<br><b>3/19/07</b>   |  | 20c. Location - City or Town, State<br><b>West Chester, PA</b>                                 |
|   | 21. Signature of Funeral Service Licensee<br><b>Kuster Amyl Englesber</b>   |  |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.<br/>Aberdeen, Maryland 21001-3399</b>                               |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>END-STAGE CHRONIC OBSTRUCTIVE PULMONARY DZ</b><br>Due to (or as a consequence of):<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>ACUTE RENAL FAILURE</b> |  |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |   |  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred  |   |  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>M. O.</b>   |   |  | 29c. License number<br><b>640670</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH, 10<sup>th</sup>, 2007</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MONIQUE PRATT - URBANAMA MD UNION HOSPITAL 106 BOW ST. ELKTON, M.D.</b>  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 16 2007</b>   |   |  | 32. Registrar's Signature<br><b>Robert B. Spaul</b>  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08410

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
James C. Mason2. Date of Death  
March 1, 20073. Time of Death  
2158 M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center Cheverly

4c. County of Death  
P.G.Funeral  
Director5. Social Security Number  
577-40-11806. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
80 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (Month, Day, Year)  
April 24, 269. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Md.10b. County  
P.G.10c. City, Town or Location  
Mount Rainier10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

2703 Webster St. Apt. # 2

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Date: 8/22/4413. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Porter16b. Kind of Business/Industry  
Railroad

17. Father's Name (First, Middle, Last)

James C. Mason

18. Mother's Name (First, Middle, Maiden Surname)

Rose B. Jones

19a. Informant's Name/Relationship (Type, Print)

Kimberly Griffin-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2703 Webster St. #2 Mount Rainier Md. 20712

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Cheltenham  
Veterans CemeteryDate  
March 7, 200720c. Location - City or Town, State  
Cheltenham, Md.

21. Signature of Funeral Service Licensee

John E. Robinson Jr.

22. Name and Address of Facility

Wash. D.C. 20001  
Robinson Funeral Home 1313 6th St. NW23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Klebsiella pneumoniae

Due to (or as a consequence of):

b. Multiple decubiti

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

Diabetes mellitus

pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Boyce

29c. License number

D0043662

29d. Date signed (Month, Day, Year)

3/1/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyce PG Hospital 3001 Hospital Dr. Cheverly, Md

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

B. B. B.

State  
Registrar

Baltimore, Maryland 21215-0036

pennil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08411

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Maxted

2. Date of Death  
Month Day Year  
March 7, 20073. Time of Death  
0145 AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Chester River Hospital Center

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

568-42-6668

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/20/1935

9. Birthplace (State or Foreign Country)

CA

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CHESTER

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

202 ELLICOTT DRIVE

10f. Zip Code

21619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

ENGINEERING

17. Father's Name (First, Middle, Last)

DAVID MAXTED

18. Mother's Name (First, Middle, Maiden Surname)

LORRAINE WOOD MONTGOMERY

19a. Informant's Name/Relationship (Type, Print)

SEVAL J. FITZPATRICK/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 WINCHESTER DRIVE, CENTREVILLE, MD 21617

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHESAPEAKE CREMATION

Date

03/08/2007

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

Kirk J. J. J.

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME, PA  
130 SPEE ROAD, CHESTERTOWN, MD 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. END-STAGE CHRONIC OBSTRUCTIVE PULMONARY  
DISEASEApproximate  
Interval Between  
Onset and Death

6 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Helen A. Noble MD

29c. License number

D0041587

29d. Date signed (Month, Day, Year)

3/7/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELEN NOBLE MD, 122 SPEE

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
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once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08412

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roy Spencer McQueen

2. Date of Death  
Month Day Year  
February 28 20073. Time of Death  
11:51A M

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

244-34-0911

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 28, 1928

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3527 Terrace Drive #B

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Safeway/Private

17. Father's Name (First, Middle, Last)

Sylvester McQueen

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Campbell

19a. Informant's Name/Relationship (Type, Print)

Rolanda E. Thomas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2146 W. Patapsco Ave., Baltimore, MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

3/6/2007

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., NE Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. multiple Myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William T. Fanner

29c. License number

D35206

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William T. Fanner

11701 Livingston Road, Fort Washington, Maryland

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08413

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Martha Helen Paine Miller   |  | 2. Date of Death<br>Month Day Year<br>March 1, 2007   |   | 3. Time of Death<br>1:25 PM  |  |
| 4a. Facility Name (If not institution, give street and number)<br>Beverly Living Ctr of Cumberland  |  | 4b. City, Town, or Location of Death<br>Cumberland  |   | 4c. County of Death<br>Allegany  |  |
| 5. Social Security Number<br>415-12-1778  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>86 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>07/06/1920   | 9. Birthplace (State or Foreign Country)<br>Michigan   |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br>MD  | 10b. County<br>Allegany  | 10c. City, Town or Location<br>Cumberland   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>40 Gleason Street   |  | 10f. Zip Code<br>21502  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 2                                |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Air Intelligence Analyst   |  | 16b. Kind of Business/Industry<br>U.S. Government   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Sterling Larkett Paine   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Martha Helen Mitchell  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Barbara Fridinger / Niece   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11 Columbia Street, Cumberland, MD 21502 |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunset Memorial Park  |   | 20c. Location - City or Town, State<br>Cumberland, MD  |  |
| 21. Signature of Funeral Service Licensee<br>Robert C. Adams  |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502                                       |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Cerebrovascular Accident  |  |   |   |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br>Sunil K. Gupta   |  | 29c. License number<br>D0033286   |   | 29d. Date signed (Month, Day, Year)<br>March 2, 2007   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, Maryland 21502   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 02 2007  |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08414

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
(Medical  
Examiner)

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
(Medical  
Examiner)Funeral  
Director

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>Mabel E. Miller   |  | 2. Date of Death<br>Month Day Year<br>March 6, 2007   |  | 3. Time of Death<br>2:45 A M  |  |
| 4a. Facility Name (If not institution, give street and number)<br>WMHS-Braddock Campus  |  | 4b. City, Town, or Location of Death<br>Cumberland  |  | 4c. County of Death<br>Allegany   |  |
| 5. Social Security Number<br>182-14-1434  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>88 Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br>09/25/1918   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  |   |  |
| 10a. State<br>PA  |  | 10b. County<br>Bedford  |  | 10c. City, Town or Location<br>Bedford  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>116 E. Pitt Street  |  | 10f. Zip Code<br>15522  |  |
| 10g. Citizen of What Country?<br>USA  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Home  |  |
| 17. Father's Name (First, Middle, Last)<br>Elmer O. Turner  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minnie S. Mowry  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert K. Miller / son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>399 Patio Ranch Road, Bedford, PA 15522  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dry Ridge Cemetery  |  | 20c. Location - City or Town, State<br>03/08/2007 Manns Choice, PA  |  |
| 21. Signature of Funeral Service Licensee<br>Robert C. Adkins   |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. RENAL FAILURE<br>Due to (or as a consequence of):<br>b. HYPERTENSION<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br>ONE WEEK<br>TEN YEARS   |  |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PNEUMONIA<br>END STAGE CONGESTIVE HEART FAILURE<br>DEMENTIA   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.            |  | 29b. Signature and title of certifier<br>Robert C. Adkins   |  | 29c. License number<br>D33417   |  |
| 29d. Date signed (Month, Day, Year)<br>March 6, 2007  |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>James R. Moen, M.D., 1068 National Highway, LaVale, Maryland 21502  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 06 2007  |  | 32. Registrar's Signature<br>James R. Moen  |  |   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08415

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Junior MCLUCAS

2. Date of Death

Month Day Year  
March 6<sup>th</sup> 2007

3. Time of Death

5:07 AM

4a. Facility Name (If not institution, give street and number)

205 Rock Willow Avenue

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-20-4533

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

8. Date of Birth (Month, Day, Year)

July 28 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

205 Rock Willow Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Charles E. McLucas

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn D. Kaylor

19a. Informant's Name/Relationship (Type, Print)

Joanne McLucas - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Rock Willow Avenue, Hagerstown, Md. 21740

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

3/9/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Colon Cancer

Approximate Interval Between Onset and Death

7 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

041667

29d. Date signed (Month, Day, Year)

3-7-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McCormack 1110 Medical Campus Hagerstown MD.

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08416

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Betty Margaret MURPHY

2. Date of Death

March 3 2007

3. Time of Death

19:58 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

293-14-6912

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

8. Date of Birth (Month, Day, Year)

May 1 1919

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20009 Rosebank Way

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

Roy Gentry Pearce

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie McKinney

19a. Informant's Name/Relationship (Type, Print)

Ken Murphy - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11827 Partridge Trail, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

3/6/07

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or other medical conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Renal failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

17 M.S.

14 year.

23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marilyn J. May

29c. License number

D28365

29d. Date signed (Month, Day, Year)

2-6-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANZAN. J. S. N. 268 miles Street Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's Signature

Brian B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

06H-20

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08417

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lee Myers

2. Date of Death

February 27, 2007

3. Time of Death

5:17 P M

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-66-0976

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

8. Date of Birth

Jan. 1, 1931

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

333 Mill Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9College (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Caregiver

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Howard Edgar Miller

18. Mother's Name (First, Middle, Maiden Surname)

Emma Rebecca Bryning

19a. Informant's Name/Relationship (Type, Print)

Todd Stotler (Grandson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6216 Sharpsburg Pk. Sharpsburg, Maryland 21782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory Mar. 1, 2007

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home P. A. 425 S. Conococheague St.  
Williamsport, Maryland 2179523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

Pneumonia

2 weeks

b. Due to (or as a consequence of):

Respiratory failure

2 weeks

c. Due to (or as a consequence of):

Congestive heart failure

2 weeks

d. Due to (or as a consequence of):

Septic Shock.

2 weeks.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Renal mass

Coronary artery disease.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

March 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Malik MD 26311 Lappans Rd Boonsboro MD 21713

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2007 08418

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA E. NORMENT

2. Date of Death  
Month Day Year

03

03

07

3. Time of Death

8:40A M

4a. Facility Name (If not institution, give street and number)

HOMWOOD RETIREMENT CENTER

4b. City, Town, or Location of Death

WILLIAMSPORT MD

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

214-09-3679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

8. Date of Birth (Month, Day, Year)

Oct. 4, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11305 Manse Road

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Boyd Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Lida Blair

19a. Informant's Name/Relationship (Type, Print)

Suanne Stouffer Yates/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11305 Manse Road, Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

3/8/2007

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

SEVERAL YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MACULAR DEGENERATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47234

29d. Date signed (Month, Day, Year)

03/04/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KELLI STRAWS 13424 PENNSYLVANIA AVENUE HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08419

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LENORA

ODEN

2. Date of Death

Month

Day

3. Time of Death

Feb. 26, 2007 7:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SALISBURY REHAB

&amp; NURSING CENTER

4b. City, Town, or Location of Death

SALISBURY, MD. 21804

4c. County of Death

WICOMICO

5. Social Security Number

162-01-1516

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 17, 1916

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

300 ARTIC AVE.

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH

DeBELLA

18. Mother's Name (First, Middle, Maiden Surname)

GENEVA

SAVAGE

19a. Informant's Name/Relationship (Type, Print)

JoANN CUOMO/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 ARTIC AVE., OCEAN CITY, MARYLAND 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HOLY CROSS CEMETERY

Date

3/5/07

20c. Location - City or Town, State

YEADON, PA

21. Signature of Funeral Service Licensee

[Signature] MO1343

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

029349

29d. Date signed (Month, Day, Year)

2/26/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

MAR 01 2007

32. Registrar's Signature

[Signature]

State  
RegistrarLenora Oden  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08420

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Mary Post

2. Date of Death  
Month Day Year

FEBRUARY 28 2007

3. Time of Death

2012 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

156-24-3093

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

8. Date of Birth (Month, Day, Year)

July 12, 1933

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8661 Island Point Drive

10f. Zip Code

21830

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Branch Manager

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Everett VanZile

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Evans

19a. Informant's Name/Relationship (Type, Print)(daughter)

Patricia Post - Campbell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14580 Foltz Drive Eden, MD 21822

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva

3-1-2007

20c. Location - City or Town, State

Delmar, Delaware

21. Signature of Funeral Service Licensee

Amy Short-Jewell

22. Name and Address of Facility

Short Funeral Home

13 E. Grove St. Delmar, DE 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alon Davis MD

29c. License number

054127

29d. Date signed (Month, Day, Year)

3/1/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alon DAVIS MD 100 Power St. Salisbury MD 21804

31. Date filed (Month, Day, Year)

MAR 02 2007

32. Registrar's Signature

Kenna H. Sparks

State  
Registrar

Julia Post 156-24-3093

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08421

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joyce Evelyn Peggins

2. Date of Death  
Month Day Year  
February 27, 20073. Time of Death  
11:50 M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

218-30-2967

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

09/04/1931

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15919 Jerald Road

10f. Zip Code

20707

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Walter Edgar Payne

18. Mother's Name (First, Middle, Maiden Surname)

Evangeline Smith

19a. Informant's Name/Relationship (Type, Print)

John W. Peggins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8400 Snowden Loop Court, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Immaculate Heart of Mary

Date

03/03/2007

20c. Location - City or Town, State

Lexington Park, MD

21. Signature of Funeral Service Licensee

Kyle S. Simons MO1206

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPTIC SHOCK.

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): FUNGAL ENDOCARDITIC.  
b. Due to (or as a consequence of): ATRIAL FIBRILLATION.  
c. Due to (or as a consequence of): THROMBOCYTOPENIA.  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE ON DIALYSIS  
HYPERTENSION  
DIABETES TYPE II

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SHARAD SHAMIM, MD

29c. License number

D-59284

29d. Date signed (Month, Day, Year)

2/28/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARAD SHAMIM, MD, WASHINGTON ADVENTIST HOSP, TAKOMA PARK MD-20912

State Registrar

MAR 02 2007

32. Registrar's Signature

Sharon K. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08422

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |  |   |  |
|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edith M Price</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>February 27 2007</b>   |  | 3. Time of Death<br><b>1135 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Chester River Hospital Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Chestertown</b>  |  | 4c. County of Death<br><b>Kent</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>222-07-3487</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth<br>Month Day Year<br><b>12/24/1921</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>DE</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>QUEEN ANNE'S</b>  |  | 10c. City, Town or Location<br><b>MILLINGTON</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>213 GROFF ROAD</b>   |  | 10f. Zip Code<br><b>21651</b>   |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ASSEMBLY LINE WORKER</b>  |  | 16b. Kind of Business/Industry<br><b>FOOD SERVICES</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JAMES CALVIN BICKLING</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDITH LOCKWOOD</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SETH A. PRICE, III/SON</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26000 JEBB ROAD, CAMDEN-WYOMING, DE 19934</b>   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MILLINGTON ASBURY CEM. 03/02/2007 MILLINGTON, MD</b>   |  |   |  |
|  | 20c. Location - City or Town, State   |  |  |  | 21. Signature of Funeral Service Licensee<br>   |  |   |  |
|  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA<br/>130 SPEER ROAD, CHESTERTOWN, MD 21620</b>  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Renal Failure</b><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br><b>Diabetes</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br><b>M</b><br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |
| 28d. Describe how injury occurred  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |
| 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br><b>D3605X</b>   |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2-27-07</b>  |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PATRICK SYLWATIA 120 SPEER Rd CHESTERTOWN MD 21620</b>  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |   |  |  | 32. Registrar's Signature<br>  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08423

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Brent Arthur Rule

2. Date of Death

Month Day Year  
March 7, 2007

3. Time of Death

7:40 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

27312 Harpers Ct.

4b. City, Town, or Location of Death

Mechanicsville

4c. County of Death

St. Mary's

5. Social Security Number

456-92-0729

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 16, 1958

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27312 Harpers Ct.

10f. Zip Code

20659

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Data Analyst Engineer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

James Arthur Rule

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Mae Shorb

19a. Informant's Name/Relationship (Type, Print)

Karen Rule (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27312 Harpers Ct., Mechanicsville, MD 20659

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Cre.

03/09/2007

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Kyle S. Simons M01206

22. Name and Address of Facility

Brinsfield Funeral Home P.A.  
22955 Hollywood Rd., Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

metastatic Renal cell carcinoma

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

10  
20  
D. S. S. S.

29c. License number

D 50686

29d. Date signed (Month, Day, Year)

MARCH 8<sup>th</sup> 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gurdeep Chhabra, MD. 25500 Point Lookout Road Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

MAR 09 2007

32. Registrar's Signature

10  
20  
D. S. S. S.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08124

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Garnett Edwards Rawlings   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 2, 2007   |  | 3. Time of Death<br>11:30 A <sup>M</sup>   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Frostburg Village Nursing Home   |  |   |   | 4b. City, Town, or Location of Death<br>Frostburg   |  | 4c. County of Death<br>Allegany  |  |
| 5. Social Security Number<br>214-05-6825   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>90 Yrs. | 8. Date of Birth (Month, Day, Year)<br>08/30/1916   |  | 9. Birthplace (State or Foreign Country)<br>West Virginia  |  |
| Usual Residence of Decedent  |  |   |   |   |  |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Cumberland   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>515 Greene Street  |  |   |   | 10f. Zip Code<br>21502  |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Electrician  |  | 16b. Kind of Business/Industry<br>U.S. Military  |  |
| 17. Father's Name (First, Middle, Last)<br>William Henry Rawlings  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clara DeVota   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Walter J. Gordon / nephew  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>247 Kevington Place, Alameda, CA 94502   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery  |   | Date<br>03/07/2007  |  | 20c. Location - City or Town, State<br>Cumberland, MD  |  |
| 21. Signature of Funeral Service Licensee<br>Robert C. Adams   |  |   |   | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Bilateral Pneumonia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 weeks |  |   |   |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |   |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |   |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive heart failure. Ischemic<br>Cardiomyopathy. Hypoalbuminemia  |  |   |   |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>SL Sandhir MD  |   | 29c. License number<br>D 14464  |  | 29d. Date signed (Month, Day, Year)<br>03/05/2007  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sikander L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, MD 21532  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 06 2007   |  |   |   | 32. Registrar's Signature<br>[Signature]  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

2007 08425

Reg. No.

Time of Death  
**7:00 AM**

4c. County of Death

## QUEEN ANNE'S

9. Birthplace (State or Foreign Country)  
**CONNECTICUT**

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10g. Citizen of What Country?  
**USA**

14. Race - American Indian,  
Black, White, etc.  
Specify: **WHITE**

16b. Kind of Business/Industry  
**AUTOMOTIVE**

18. Mother's Name (First, Middle, Maiden Surname)  
**ALICE ORLOSKI**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**2706 SHERMAN DRIVE, CHESTER, MARYLAND 21619**

20c. Location - City or Town, State

22. Name and Address of Facility  
**FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.**  
**106 SHAMROCK ROAD, CHESTER, MARYLAND 21619**

Due to (or as a consequence of):

b. \_\_\_\_\_ Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

23c. If yes, outcome of pregnancy

|  |  |  |
|--|--|--|
| 1 <input type="checkbox"/> Live birth                | 2 <input type="checkbox"/> Fetal death           | 3 <input type="checkbox"/> Ectopic pregnancy |
| 4 <input type="checkbox"/> Pregnant at time of death | 5 <input type="checkbox"/> Other (specify) _____ |  |
| 9 <input type="checkbox"/> Unknown                   |  |  |

23d. Date of delivery  
Month                  Day                  Year

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes    2 ☒ No    3 ☐ Probably    4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes    2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

|                                   |  |
|-----------------------------------|--|
| 28d. Describe how injury occurred |  |
|-----------------------------------|--|

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMIE HARMON m 115 SALLITT DRIVE STEWENSVILLE m 21664

31. Date filed (Month, Day, Year)

34. Registrar's Signature

(Month, Day, Year)  
MAR 6 2007

DMMH 17 Rev 1/2001

ORIGINAL

Nicholas Stephen Sabath

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08426

1- For State Registrar

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas Stephen Sabath

2. Date of Death  
Month Day Year  
March 7, 20073. Time of Death  
1903 hrs

4a. Facility Name (if not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

212-76-3727

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Nov. 30, 1957

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21338 Leitersburg Pike

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cabinet Maker

16b. Kind of Business/Industry

Woodworking

17. Father's Name (First, Middle, Last)

Stanley Sabath

18. Mother's Name (First, Middle, Surname)

Margaret Elizabeth Simon

19a. Informant's Name/Relationship (Type, Print)

Stephanie a. Sabath/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21338 Leitersburg Pike, Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

3/11/2007

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

*S. Mark Sipp*

22. Name and Address of Facility

Rest Haven Funeral Chapel  
1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part I. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☒ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Mar 7, 2007

28b. Time of Injury

1824 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver auto auto collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Major Road / Highway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21123 Leitersburg Parkway, Hagerstown, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

*Quetz*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2007

30. Name and address of person who attended cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

*Kevin B. Spiller*

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08427

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Burns Shearer

2. Date of Death  
Month Day Year  
March 11, 20073. Time of Death  
0212 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

213-03-5259

6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
Yrs. 888. Date of Birth (Month, Day, Year)  
March 31, 19189. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

121 Elkside Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Rubber Products  
Manufacturing

17. Father's Name (First, Middle, Last)

Andrew M. Burns

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Fadeley

19a. Informant's Name/Relationship (Type, Print)

Donald I. Shearer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 Elkside Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Immaculate  
Conception CemeteryDate  
March 14,

2007

20c. Location - City or Town, State

Cherry Hill, Maryland

21. Signature of Funeral Service Licensee

Donald I. Shearer

22. Name and Address of Facility

Hicks Home for Funerals, P.A.  
103 W. Stockton Street, Elkton, Maryland 2192123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis Shock  
Due to (or as a consequence of):b. Pneumonia and  
Due to (or as a consequence of):c. Osteomyelitis  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and DeathDays  
Days  
DaysSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John R. Mulvey, M.D.

29c. License number

D45755

29d. Date signed (Month, Day, Year)

03/12/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John R. Mulvey, M.D., 111 W. High St., Suite 309, Elkton, Maryland 21921

31. Date filed (Month, Day, Year)

MAR 16 2007

Registrar's Signature

John R. Mulvey

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08428

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Smith Shockey

2. Date of Death

March 10, 2007

3. Time of Death

9:30 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

23200 Ringgold Pike

4b. City, Town, or Location of Death

Smithsburg

4c. County of Death

Washington

5. Social Security Number

219-60-1628

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Oct. 23, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23200 Ringgold Pike

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Herman S. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mary A. Webster

19a. Informant's Name/Relationship (Type, Print)

James N. Shockey (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23200 Ringgold Pike Smithsburg, Maryland 21783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Smithsburg Crematory

Date

March 12,

2007

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

J. Lee Davis MD1414

22. Name and Address of Facility

J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Bladder cancer.

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 26806

29d. Date signed (Month, Day, Year)

March 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUDY HOND 13424 Pennsylvania Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

J. Lee Davis

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08429

|   |  |   |  |  |   |  |  |  |
|---|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John Joseph Siebenkas  |   |  |  | 2. Date of Death<br>Month: MARCH Day: 3 Year: 2007  |  | 3. Time of Death<br>8:04 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Mary's Hospital  |   |  |  | 4b. City, Town, or Location of Death<br>Leonardtwn  |  | 4c. County of Death<br>St. Mary's  |  |
| Funeral<br>Director   | 5. Social Security Number<br>123-34-4623   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>61 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>May 16, 1945  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10. Usual Residence of Decedent<br>10a. State: Maryland 10b. County: St. Mary's 10c. City, Town or Location: Hollywood 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: |  |
| To Be Completed by Funeral Director   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2   |  | 16. Kind of Business/Industry<br>US Government Contractor  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Max Siebenkas   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia DeRosa  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Lou Siebenkas / Wife  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24501 Mt. Pleasant Road Hollywood, MD 20636  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  | 20c. Location - City or Town, State<br>Alexandria, Virginia   |  | 20d. Date<br>March 6, 2007   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael K. Gardiner</i>  |   |  |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270 Leonardtown, MD 20650  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cardio respiratory arrest</i><br>Due to (or as a consequence of):<br>b. <i>CAD</i><br>Due to (or as a consequence of):<br>c. <i>ESRD on dialysis</i><br>Due to (or as a consequence of):<br>d. <i>Severe PVD</i> |   |  |  |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month: Day: Year:   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>D. Shah</i>   |  |   |  | 29c. License number<br><i>D 47066</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>3.4.07</i>                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>AVANI D SHAH LEONARDTOWN MARYLAND 20650   |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 05 2007  |  | 32. Registrar's Signature<br><i>John B. Spotts</i>  |  |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08430

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERMA D. SIZEMORE

2. Date of Death

MARCH 4, 2007

3. Time of Death

01:30 A M

4a. Facility Name (If not institution, give street and number)

CHESTER RIVER HOSPITAL CENTER

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

Funeral  
Director

5. Social Security Number

220-01-8255

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

03/28/1903

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

MILLINGTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

304 RACE STREET

10f. Zip Code

21651

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ASSEMBLY LINE WORKER

16b. Kind of Business/Industry

FOOD PROCESSING

17. Father's Name (First, Middle, Last)

DEMON WILKERSON

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print)

PEARL M. CLARK/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 BEDFORD LANE, NEW CASTLE, DE 19720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

UNION CEMETERY

Date

03/10/2007

20c. Location - City or Town, State

GOLDSBORO, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME, PA  
370 CYPRESS STREET, MILLINGTON, MD 2165123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

HTN

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

7/5/16

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Extremities

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P 3654

29d. Date signed (Month, Day, Year)

3-5-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick S. Harahan 120 SPER Rd. CHESTERTOWN MD 21620

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08431

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Lee Short

2. Date of Death

March 01, 2007

3. Time of Death

08:00 A M

4a. Facility Name (If not institution, give street and number)

150 Frost Avenue

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

215-68-7164

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 11, 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number 150 Frost Avenue

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

disabled

16b. Kind of Business/Industry

disabled

17. Father's Name (First, Middle, Last)

Paul W. Short

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Paul

19a. Informant's Name/Relationship (Type, Print)

Pearl Short

mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

150 Frost Avenue

Frostburg

Maryland

21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Emmanuel Methodist Cemetery

Date

March 03, 2007

20c. Location - City or Town, State

Finzel

Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Respiratory failure

b. Due to (or as a consequence of):

Seizure disorder

c. Due to (or as a consequence of):

Cerebral Palsy

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Life long seizure

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia  
Skeletal deformities

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John R. Durst

29c. License number

D22029

29d. Date signed (Month, Day, Year)

3/1/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riaz A. Janjua, M.D. 625 Kent Ave., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

John R. Durst

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08432

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Gerard Souders

2. Date of Death

Month Day Year  
March 3 2007 16:04 M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral  
Director

5. Social Security Number

210-54-0574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 16 1962

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15049 Terra Lane

10f. Zip Code

21795

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Tire Company

17. Father's Name (First, Middle, Last)

Milton Hayes Souders

18. Mother's Name (First, Middle, Maiden Surname)

Doris Joanne Kelsey Hull

19a. Informant's Name/Relationship (Type, Print)

Deborah K. Souders (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15049 Terra Lane Williamsport Maryland 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery

Date

March 7 07

20c. Location - City or Town, State

Hagerstown Maryland

21. Signature of Funeral Service Licensee

Douglas A. Fiery

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd. N. Hagerstown Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Atherosclerotic Coronary Disease  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Douglas A. Fiery MD

29c. License number

D0056965

29d. Date signed (Month, Day, Year)

March 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Kotz, MD 251 E. Antietam Street Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Brian B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08433

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23b or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |                                |  |   |
|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen Virginia Smith</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>3</b> Year <b>2007</b>  |                                | 3. Time of Death<br><b>10:45 A M</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Woodside Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |                                | 4c. County of Death<br><b>Montgomery</b>   |   |
| 5. Social Security Number<br><b>228-18-6324</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 28, 1907</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |                                |  |   |
| Usual Residence of Decedent   |  |   |                                |  |   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>9101 Second Avenue</b>   |  | 10f. Zip Code<br><b>20910</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |                                |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |                                | 16b. Kind of Business/Industry<br><b>U.S. Department of Agriculture</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Alvey Smith</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie M. Michael</b>   |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Smith - self by pre arrangement</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9101 Second Avenue, Silver Spring, Md. 20910</b>  |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |   |
| 20d. Date<br><b>3/06/07</b>   |  |   |                                |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>  |  | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiomyopathy</b><br>Due to (or as a consequence of):   |  |   |                                |  |   |
| b. <b>Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):   |  |   |                                |  |   |
| c.<br>Due to (or as a consequence of):  |  |   |                                |  |   |
| d.<br>Due to (or as a consequence of):  |  |   |                                |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |                                |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown  |  | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify)  |                                | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |   |
| 29b. Signature and title of certifier<br><b>Rachana</b>   |  | 29c. License number<br><b>D20108</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>March 5, 2007</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rakesh Arora M.D. 14300 Gallant Fox Lane, Suite 221, Bowie, Maryland 20715</b>   |  |   |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |                                |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08434

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HATTIE ANN TAYLOR

2. Date of Death

Month 3 Day 1 Year 07

3. Time of Death

1030 M

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

Wicomico

5. Social Security Number

220-32-9889

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10-2-22

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

SNOW HILL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5539 VOTING HOUSE RD

10f. Zip Code

21863

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

WILLIAM FISHER

18. Mother's Name (First, Middle, Maiden Surname)

HATTIE STEVENSON

19a. Informant's Name/Relationship (Type, Print)

CORINDA ROBINS-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1619 WILCONIA DRIVE, SALISBURY, MD 21861

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TAYLOR GATE CEM.

Date

3/7/07

20c. Location - City or Town, State

SNOW HILL, MD

21. Signature of Funeral Service Licensee

Phyllis Rouns

22. Name and Address of Facility

BENNIE SMITH FH 917-W. ISABELLA ST. SALISBURY, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

a. Due to (or as a consequence of):

Hypertension

b. Due to (or as a consequence of):

Diabetes and hypokalemia

c. Due to (or as a consequence of):

C. Diff Colitis

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

Renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Coker

29c. License number

H56197

29d. Date signed (Month, Day, Year)

3/2/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT COKER 218 NEWTON ST. SALISBURY MD 21801

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

Karen H. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2007 08435

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Thompson

2. Date of Death  
Month Day Year

March 2, 2007

3. Time of Death

7:20 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

579-18-3495

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02/06/1922

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Leonardtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23670 Rocky Ridge Court

10f. Zip Code

20650

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Burton Emory Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Frances Richardson

19a. Informant's Name/Relationship (Type, Print)

Ralph Lee Thompson/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23670 Rocky Ridge Court, Leonardtown, MD 20650

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Brinsfield-Echols Cr. 03/04/2007

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Kyle S. Simons M01206

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia: Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

3-3-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Jarboe, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

James P. Jarboe

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08636

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Ernest Thompson, Jr.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 27, 2007</b>   |                                | 3. Time of Death<br><b>4:40 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |                                | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>043-14-9297</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 10, 1922</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1111 Little Magothy View</b>  |  |   |  | 10f. Zip Code<br><b>21409</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>1</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Product Manager</b>  |                                | 16b. Kind of Business/Industry<br><b>Food</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Ernest Thompson, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harriet Ferris</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vivienne F. Thompson/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1111 Little Magothy View Annapolis, MD 21409</b>   |                                |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>  |  | Date<br><b>3/1/2007</b>  |                                | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ford E. Liller</b>   |  |   |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home<br/>147 Duke of Gloucester St., Annapolis, MD 21401</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Parkinsons Disease</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c. Skin Cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |                                |  |  |
| Approximate Interval Between Onset and Death   |  |   |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify)   |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |                                |  |  |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Bolaji Onabajo</b>   |  |   |  | 29c. License number<br><b>D 45149</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>February 27, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Bolaji Onabajo 301 Hospital Drive Glen Burnie, Maryland 20161</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 01 2007</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



## Certificate of Death

Reg. No.

2007 08437

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Martha Ella Thorne

2. Date of Death

Month Day Year  
March 10, 2007

3. Time of Death

9:22 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Julia Manor Healthcare Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-18-3293

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 11, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Sharpsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 117 / 112 S. Mechanic St.

10f. Zip Code

21782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Allen Grafton McGraw

18. Mother's Name (First, Middle, Maiden Surname)

Edith Verbelle Bender

19a. Informant's Name/Relationship (Type, Print)

Vernon G. Thorne (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 117 / 112 S. Mechanic St. Sharpsburg, MD 21782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsbur Crematory

Date

March 12,  
2007

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

J. L. Davis MO1414

22. Name and Address of Facility

J.L. Davis Funeral Home  
12525 Bradbury Ave. Smithsburg, Maryland 2178323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Lung Cancer  
Due to (or as a consequence of):b. Chronic obstructive Pulmonary Disease 25x  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6m

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

PS 2323

29d. Date signed (Month, Day, Year)

03-12-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Waseem 1126 Opal Crt. Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

James B. Speltz

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08438

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Hendrick Uglow</b>   |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>6</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>09:55A M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtwn</b>   |  | 4c. County of Death<br><b>St. Mary's</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>410-32-5917</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>09/30/1923</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Missouri</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Lexington Park</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>48791 Havirland Road</b>   |  | 10f. Zip Code<br><b>20653</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>                  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Civil Service</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John William Hendrick</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Armenta Perry</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Harwood/ Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 838, St. Inigoes, Maryland 20684</b>     |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>First Friendship UMC</b>   |  | 20c. Location - City or Town, State<br><b>Ridge, Maryland</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Kyle S. Simons M01206</b>   |  |  |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, Maryland 20650</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Altered Mental Status</b><br>Due to (or as a consequence of):<br><b>COMA</b><br><b>HEART ATTACK</b><br><b>Diabetes</b> |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  |   |  |
|   | 28b. Time of Injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Dr. Manoj D Panwala</b>   |  |  |  | 29c. License number<br><b>D55027</b>  |  |   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>3-7-7</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MANOJ D PANWALA CHARLOTTE HALL MARYLAND 20622</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>MAR 09 2007</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |
|   | State Registrar   |  |  |  | DHMH 17 Rev 1/2001  |  |   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08439

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annabelle Marie Vitt

2. Date of Death

Month Day Year  
March 04 2007

3. Time of Death

0355 AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral  
Director

5. Social Security Number

217-30-7215

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept 7 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Washington

10c. City, Town or Location

Maugansville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14007 Village Mill Drive

10f. Zip Code

21767

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William W. Elliott

18. Mother's Name (First, Middle, Maiden Surname)

Harriet R. Mills Elliott

19a. Informant's Name/Relationship (Type, Print)

Harold D. Jones (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17825 Sherman Ave. Hagerstown Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Broadfording Cemetery

Date

Mar 8 2007

20c. Location - City or Town, State

Hagerstown Maryland

21. Signature of Funeral Service Licensee

Douglas A. Fiery

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. N. Hagerstown Maryland 21742

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Electrolyte imbalance

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. gastroenteritis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Douglas A. Fiery

29c. License number

021457

29d. Date signed (Month, Day, Year)

3-5-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDOL WAHERED, MD - 12821 - OAKHILL AVE HAGERSTOWN, MD 21742

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2007

32. Registrar's Signature

Brian B. Spivey

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08440

Physician/  
Medical Examiner

Funeral  
Director

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Queenie Victoria Green Vaughan

2. Date of Death

Month Day Year  
March 7, 2007

3. Time of Death

1530 hrs

4a. Facility Name (if not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

224-38-2772

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

February 17, 1935

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7907 Fowlers Court

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Private Duty Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Edward Green

18. Mother's Name (First, Middle, Maiden Surname)

Martha Ellen Green

19a. Informant's Name/Relationship (Type, Print)

Deborah Vaughan-Gaines / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7907 Fowlers Court Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

03/13/2007

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home PA

6160 Oxon Hill Road Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy with biventricular hypertrophy and atherosclerotic

Due to (or as a consequence of): cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

☒ UNPENDED

☐ AMENDED

#23a, PII, 27, per ME, C867, 5/10/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Terminal renal disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 16 2007

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2007 08441

|   |  |   |   |  |   |  |   |  |  |  |
|---|--|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Rita Florine Wible   |   |   |  | 2. Date of Death<br>Month: March, Day: 1, Year: 2007  |  |   |  | 3. Time of Death<br>7:45 P M   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Mary's Nursing Center  |   |   |  | 4b. City, Town, or Location of Death<br>Leonardtwn  |  |   |  | 4c. County of Death<br>St. Mary's  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-22-2294   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>June 19, 1926        |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent  |   |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>St. Mary's   |  | 10c. City, Town or Location<br>California   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>44693 White Oak Court #519   |   |   |  | 10f. Zip Code<br>20619  |  | 10g. Citizen of What Country?<br>USA                        |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |   | 16b. Kind of Business/Industry<br>Own Home   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Edwin Parran Johnson  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Agnes Florine Raley  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Reeder / Daughter   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>44693 White Oak Court #519 California, MD 20619  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens  |  | Date<br>March 5, 2007   |  | 20c. Location - City or Town, State<br>Leonardtwn, Maryland |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Michael R. Andriener  |   |   |  | 22. Name and Address of Facility<br>Matingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270 Leonardtown, MD 20650   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Respiratory Failure<br>Due to (or as a consequence of):<br>Congestive Heart Failure<br>Due to (or as a consequence of):<br>Coronary Artery DE.<br>Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>Days<br>Wks<br>Yrs |   |   |  |   |  |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  |   |  | 23d. Date of delivery<br>Month: Day: Year:                  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia  |  |   |   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>James P. Jarboe, M.D.  |   |  |   | 29c. License number<br>D 06419   |   | 29d. Date signed (Month, Day, Year)<br>3-2-07  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>24035 Three Notch Road Hollywood, MD 20636  |  |   |   | 31. Date filed (Month, Day, Year)<br>MAR 05 2007                             |   |  |   |  |  |  |
| 32. Registrar's Signature<br>[Signature]  |  |   |   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Kenneth James Walter

State of Maryland / Department of Health and Mental Hygiene

2007 08442

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|  |  |  |                                     |
|--|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kenneth J. Walter</b> |  | 2. Date of Death<br>Month <b>February</b> Day <b>27</b> Year <b>2007</b> | 3. Time of Death<br><b>0707 hrs</b> |
|--|--|--|-------------------------------------|

Funeral  
Director

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>21610 Liberty Street Apt. 002</b> |  | 4b. City, Town, or Location of Death<br><b>Lexington Park</b> |  | 4c. County of Death<br><b>St. Mary's</b>                |   |
| 5. Social Security Number<br><b>101-66-3647</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>24</b> Yrs.              | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>October 5, 1982</b> | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |

To Be Completed by Funeral Director

|  |                                  |   |  |
|--|----------------------------------|---|--|
| Usual Residence of Decedent  |                                  |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>St. Mary's</b> | 10c. City, Town or Location<br><b>Lexington Park</b>  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>21610 Liberty Street Apt. 002</b>   |                                  | 10f. Zip Code<br><b>20653</b>   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Aviation Mechanic</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Guy K. Walter</b>  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cynthia L. Esposito</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cynthia L. Walter / Mother</b>  |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>90 Cemetery Road Elma, NY 14059</b> |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                 |  |
| 21. Signature of Funeral Service licensee<br><i>Michael L. Gardiner</i>  |                                  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270 Leonardtown, MD 20650</b>                |  |

Baltimore, MD 21215-0036

Physician  
/Medical  
Examiner

|  |  |  |  |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death |  |
| a. Gunshot Wounds of the Head<br>Due to (or as a consequence of):  |  |  |  |
| b.<br>Due to (or as a consequence of):   |  |  |  |
| c.<br>Due to (or as a consequence of):   |  |  |  |
| d.<br>Due to (or as a consequence of):   |  |  |  |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |  |  |  |

To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Feb 27, 2007</b>  |  | 28b. Time of Injury<br><b>FOUND: 0655 hrs</b>  |  |
|   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Subject shot</b>   |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Parking Lot</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>21610 Liberty Street Apt. 002, Lexington Park, MD</b>   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Laron Locke</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 2007</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 06 2007</b>   |  | 32. Registrar's Signature<br><i>Laron Locke</i>   |  |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08443

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Frances Woodall

2. Date of Death

March 5, 2007

3. Time of Death

6:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

20594A Golden Thompson Road

4b. City, Town, or Location of Death

Avenue

4c. County of Death

St. Mary's

5. Social Security Number

216-50-9277

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 26, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
St. Mary's

10c. City, Town or Location

Avenue

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20594A Golden Thompson Road

10f. Zip Code

20609

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Benjamin Brown

18. Mother's Name (First, Middle, Maiden Surname)

Mary Roberta Ellis

19a. Informant's Name/Relationship (Type, Print)

Anna C. Kotowski / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38700 Collinwood Drive, Abell, Maryland 20606

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Charles Memorial Gardens

Date

March

10, 2007

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service Licensee

Michael J. Gaudin

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. failure to thrive

Due to (or as a consequence of):

b. Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arthritis, Sjogren's syndrome, dry eyes  
anxiety disorder

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

KAE T. AUNG

29c. License number

D 0051738

29d. Date signed (Month, Day, Year)

03/06/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAE T. AUNG, 24435 MERVILL DEAN RD, HOLLYWOOD MD 20636

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2007

32. Registrar's Signature

KAE T. AUNG

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08444

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna Hyndman Wright

2. Date of Death

March 6, 2007

3. Time of Death

8:30 A M

4a. Facility Name (If not institution, give street and number)

Bayside Nursing Center

4b. City, Town, or Location of Death

Lexington Park

4c. County of Death

St. Mary's

5. Social Security Number

108-22-1733

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

02/21/1931

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21214 Greatmills

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Hyndman

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Hyndman

19a. Informant's Name/Relationship (Type, Print)

Karen Wright Ladner / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45265 Cal Acres Lane California, Maryland 20619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Cre

Date

03/09/2007

20c. Location - City or Town, State

Charlotte Hall, MD.

21. Signature of Funeral Service Licensee

Kyle S. Simons M01206

22. Name and Address of Facility

Brinsfield Funeral Home PA.

22955 Hollywood Road Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cerebrovascular Thrombosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

seconds

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease, Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19917

29d. Date signed (Month, Day, Year)

3/7/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Boyd, MD. 23415 Three Notch Road California, Maryland 20619

31. Date filed (Month, Day, Year)

MAR 09 2007

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| 1- For State Registrar       |  | State of Maryland / Department of Health and Mental Hygiene   |  | Certificate of Death   |  | 2007 08445   |  |
|------------------------------|--|---|--|--|--|--|--|
| Physician / Medical Examiner |  | 1. Decedent's Name (First, Middle, Last)<br>SCOTT LANSING WILLIAMS  |  |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 2, 2007  |  |
| Funeral Director             |  | 3. Time of Death<br>10:15 A M   |  | 4a. Facility Name (If not institution, give street and number)<br>HERON POINT  |  | 4b. City, Town, or Location of Death<br>CHESTERTOWN  |  |
|                              |  | 4c. County of Death<br>KENT   |  | 5. Social Security Number<br>448-09-7729   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  |
|                              |  | 7. Age (In yrs. last birthday)<br>89 Yrs.   |  | 8. Date of Birth<br>Month Day Year<br>02/21/1918   |  | 9. Birthplace (State or Foreign Country)<br>OK   |  |
|                              |  | Usual Residence of Decedent   |  | 10a. State<br>MD   |  | 10b. County<br>KENT  |  |
|                              |  | 10c. City, Town or Location<br>CHESTERTOWN  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|                              |  | 10e. Street and Number<br>313 HERON POINT   |  | 10f. Zip Code<br>21620   |  | 10g. Citizen of What Country?<br>USA   |  |
|                              |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |
|                              |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>METEOROLOGIST   |  |
|                              |  | 16b. Kind of Business/Industry<br>GOVERNMENT  |  | 17. Father's Name (First, Middle, Last)<br>J. DON WILLIAMS   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY ELANDER ROBINSON   |  |
|                              |  | 19a. Informant's Name/Relationship (Type, Print)<br>MARY ELLEN WILLIAMS/WIFE  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>313 HERON POINT, CHESTERTOWN, MD 21620  |  |  |  |
|                              |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CHESAPEAKE CREMATORY   |  | 20c. Location - City or Town, State<br>STEVENSVILLE, MD  |  |
|                              |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA<br>130 SPEER ROAD, CHESTERTOWN, MD 21620   |  |  |  |
|                              |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pneumonia</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>5 days -   |  |  |  |
|                              |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
|                              |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Dehydration</u>  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|                              |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |
|                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  |
|                              |  | 29c. License number<br>D0060307   |  | 29d. Date signed (Month, Day, Year)<br>3/2/07  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MICHAEL PERMUT, MD 102 SPEER RD STE 5 CHESTERTOWN, MD 21620  |  |
|                              |  | 31. Date filed (Month, Day, Year)<br>MAR 05 2007  |  | 32. Registrar's Signature<br>  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08446

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY WOOTEN

2. Date of Death

Month Day Year  
FEB 27 20073. Time of Death  
1549 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

262-15-4991

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 27 1952

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5278 Marlboro Pike

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waiter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Troy Wooten

18. Mother's Name (First, Middle, Maiden Surname)

Marie Williams

19a. Informant's Name/Relationship (Type, Print)

Brenda Morgan Wooten - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5278 Marlboro Pike Capitol Heights MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date  
3/3/2007

20c. Location - City or Town, State

Alexandra VA

21. Signature of Funeral Service Licensee

J. J. J. J.

22. Name and Address of Facility Pope Funeral Home

5538 Marlboro pike Forestville Maryland 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. FATAL CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. J. J. J.

29c. License number

D58957

29d. Date signed (Month, Day, Year)

2-1-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR GARY LITTLE

3001 HOSPITAL DR

CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

J. J. J. J.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08447

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FANNIE

WELLS

2. Date of Death

Month

Day

Year

02

27

2007

3. Time of Death

10:35A M

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

5. Social Security Number

577-36-4621

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-10-1924

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 60th ST NE #203

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

WILLIE LEE BEASLEY

18. Mother's Name (First, Middle, Maiden Surname)

CORNELIA GRAVES

19a. Informant's Name/Relationship (Type, Print)

PATRICIA MARSHALL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

327 ELMLEAF AVE CAPITAL HEIGHTS, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON CEMETERY

Date

03-14-2007

20c. Location - City or Town, State

ARLINGTON, VA

21. Signature of Funeral Service Licensee

K. D. Marshall

22. Name and Address of Facility

JB JENKINS FUNERAL HOME  
7474 LANDOVER RD LANDOVER, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HYPERTENSIVE CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31528

29d. Date signed (Month, Day, Year)

02-28-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGARET AKPAN, MD 3001 HOSPITAL DRIVE CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

MAR 05 2007

32. Registrar's Signature

K. D. Marshall

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08448

1- For  
State  
Registrar

|   |   |  |   |   |   |   |   |  |  |  |
|---|---|--|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Larry Weller</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>February 27, 2007</b>  |   |   |  | 3. Time of Death<br><b>2:49 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |   |   |  | 4c. County of Death<br><b>Frederick</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-38-9260</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 1, 1938</b>                |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|   | Usual Residence of Decedent   |  |   |   |   |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Frederick</b>   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>8600 Chestnut Grove Road</b>   |  |   |   | 10f. Zip Code<br><b>21701</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                            |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:            |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner-Operator</b>  |   |   | 16b. Kind of Business/Industry<br><b>Landscaping Business</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Louis Parker Weller</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vivian Bosley</b>   |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type. Print)<br><b>Rosalie H. Weller - Wife</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8600 Chestnut Grove Road, Frederick, Maryland 21701</b>   |   |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematorium</b>   |   | 20c. Location - City or Town, State<br><b>3/4/07 Alexandria, Virginia</b> |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>  |  |   |   | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>  |   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |   |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dilated Cardiomyopathy</b><br><b>Ventricular Arrhythmias</b><br><b>Congestive Heart Failure</b>  |   |  |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                             |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28d. Describe how injury occurred   |   |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Alan H. Rohrer, MD DME</b>  |   |  |   | 29c. License number<br><b>D37197</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 1, 2007</b> |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alan H. Rohrer, M.D., D.M.E., 15 West Seventh Street, Frederick, Maryland 21701</b>  |   |  |   |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 05 2007</b>   |   |  |   | 32. Registrar's Signature<br><b>Alan H. Rohrer</b>  |   |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08450

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda P. Ashley

2. Date of Death  
Month Day Year  
March 12, 20073. Time of Death  
8:43 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number  
215-18-09276. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
85 Yrs.8. Date of Birth (Month, Day, Year)  
May 7, 19219. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1513 Vesper Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse Aide

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Julius Podbielski

18. Mother's Name (First, Middle, Maiden Surname)

Jadwiga Zakulska

19a. Informant's Name/Relationship (Type, Print)

Louis J. Rychwalski (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

335 Poplar Road Baltimore, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Polish National Cem. 3/16/2007 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gregory E. Reed

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)a. ASCVD  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory E. Reed

29c. License number

RES-0000

29d. Date signed (Month, Day, Year)

3/12/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory E. Reed 4940 EASTERN AVENUE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Keara B. Spotts

State  
RegistrarWanda Ashley  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08451

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanne Marie August

2. Date of Death

MARCH 13, 2007 02:30 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

138-22-1320

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Nov. 11, 1929

9. Birthplace (State or Foreign Country)

Glasboro, NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

40 Robin Hood Road #781

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Sewing

17. Father's Name (First, Middle, Last)

Samuel F. Parks

18. Mother's Name (First, Middle, Maiden Surname)

Catharine Giberson

19a. Informant's Name/Relationship (Type, Print)

Estelle Jianniney- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

40 Robin Hood Road #781 Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evans Funeral Chapel

Date

3-15-2007

20c. Location - City or Town, State

Forest Hill, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bel Air 3 Evans Funeral Chapel &amp; Cremation Services

Newport Dr. Forest Hill, MD 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DIS YEARS

Due to (or as a consequence of):

b. END STAGE RENAL DISEASE ON HEMODIALYSIS YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

29c. License number

D25886

29d. Date signed (Month, Day, Year)

March 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HAIM BALVA

2. Date of Death

Month Day Year  
MARCH 19 2007

3. Time of Death

5:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

228-45-9993

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 25 1933

9. Birthplace (State or Foreign Country)

Israel

Usual Residence of Decedent

10a. State

Israel

10b. County

10c. City, Town or Location

Tiberias

10d. Inside City Limits

☐ Yes ☐ No

10e. Street and Number

744/2 Yefe Nof St.

10f. Zip Code

21A

10g. Citizen of What Country?

Israel

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Jacob Balva

18. Mother's Name (First, Middle, Maiden Surname)

Masouda Nechmad

19a. Informant's Name/Relationship (Type, Print)

Rina Balva / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

744/2 Yefe Nof St. Tiberias Israel

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tiberias Cemetery

Date

03-21-2007

20c. Location - City or Town, State

Tiberias Israel

21. Signature of Funeral Service Licensee

Robert Prodan

22. Name and Address of Facility

Shomrei Hadas Chapels 3803 14th Ave.

Brooklyn, NY 11218

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Respiratory Distress Syndrome  
Due to (or as a consequence of):

7 days

c. Chronic Obstructive Pulmonary Disease  
Due to (or as a consequence of):

5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic gastric cancer

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher Scioritino MD/PHD

29c. License number

A54147357

29d. Date signed (Month, Day, Year)

MARCH 19 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Scioritino 4940 Eastern Avenue Baltimore Maryland 21224

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Heaven H. Spauld

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08453

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Frances Brown

2. Date of Death

March 13, 2007

3. Time of Death

9:45 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-38-5294

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

8. Date of Birth

July 27 1941

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

210 Belmont Forest Court Unit 401

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
+116a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

real estate agent

16b. Kind of Business/Industry

real estate

17. Father's Name (First, Middle, Last)

John George Smith

18. Mother's Name (First, Middle, Maiden Surname)

Christine Marie Lutz

19a. Informant's Name/Relationship (Type, Print)

Glen H. Brown (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Belmont Forest Ct., Unit 401, Timonium, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Mausoleum

Date

3-19-07

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Paul Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Carcinoma

Approximate Interval Between Onset and Death

One year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marshall A. Levine, M.D.

29c. License number

D17873

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marshall A. Levine 6569 North Charles Street Towson, Maryland

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Lena B. Speck

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

BROWN, JANE F  
Baltimore, Maryland 21215-0036  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08454

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wesley Sherman Bright

2. Date of Death

Month Day Year  
March 13, 2007

3. Time of Death

2:30am M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10542 Jason Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

217-34-2596

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 20, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10542 Jason Lane

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Phillip Bright

18. Mother's Name (First, Middle, Maiden Surname)

Estella Clark

19a. Informant's Name/Relationship (Type, Print)

Mrs. Olivia M. Bright (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10542 Jason Lane Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bushy Park Cemetery

Date

3-17-07

20c. Location - City or Town, State

Cooksville, MD

21. Signature of Funeral Service Licensee

Brian D. Hayer 000764

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)  
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC NON-SMALL CELL LUNG CANCER

Approximate  
Interval Between  
Onset and Death

= 6 Mo

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION

= 2 years

Due to (or as a consequence of):

c. Diabetes mellitus (type II.)

= 5 years

Due to (or as a consequence of):

d. HYPERTENSION

= 5 years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Lea Lazar MD

29c. License number

D38833

29d. Date signed (Month, Day, Year)

March, 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lea Lazar MD G355 TEN OAKS Rd CLARKSVILLE MD 21029

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Brian D. Hayer

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08455

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |  |   |  |
|---|---|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Norman Nicholas Beck</b>   |   |  |   | 2. Date of Death<br><b>March 12 2007</b> Year   |  | 3. Time of Death<br><b>4:13 P M</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4806 King Avenue</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore County</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217 22 2541</b>   |   | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 13 1926</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore County</b>                  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>4806 King Avenue</b>  |   | 10f. Zip Code<br><b>21236</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>   |   | 16b. Kind of Business/Industry<br><b>Armco Steel</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph William Beck</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Marx</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Norman G Beck</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1017 Brookwood Drive Joppa, Maryland 21085</b>  |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)                              |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cem.</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 20d. Date<br><b>March 16 2007</b>                                       |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Robert A. Bessie</i>  |   | 22. Name and Address of Facility<br><b>Lassahn Funeral Home Inc</b>  |   | 7401 Belair Road<br><b>Baltimore, Maryland 21236</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Multiple Myeloma with Bone Metastasis</b><br>Due to (or as a consequence of):                |   |  |   |   |  |   |  |
|   | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>b. Hypocalcemia / Ethanol use</b><br>Due to (or as a consequence of):                          |   |  |   |   |  |   |  |
|   | 23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>c. Congestive Heart Failure / coronary artery disease</b><br>Due to (or as a consequence of): |   |  |   |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No<br><b>9</b> <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><b>1</b> <input type="checkbox"/> Live birth <b>2</b> <input type="checkbox"/> Fetal death <b>3</b> <input type="checkbox"/> Ectopic pregnancy<br><b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (specify)  |  | 23d. Date of delivery<br>Month Day Year               |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypocalcemia / Ethanol use</b><br><b>Congestive Heart Failure / coronary artery disease</b>  |   |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  |   |   |  |   |  |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                       |   | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><i>Dr. M. F. Fucaldo MD</i> Attending Physician  |   | 29c. License number<br><b>00059385</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/19/07</b> |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph M. Fucaldo MD 9105 Franklin Square Drive Suite 309 Baltimore MD</b>   |   |   |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |   | 32. Registrar's Signature<br><i>Norman G. Beck</i> <b>21237</b>   |  |   |   |  |   |  |

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

NORMAN NICHOLAS BECK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08456

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LENA BAILEY</b>  |  | 2. Date of Death<br>Month <b>03</b> Day <b>14</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>9:52 A M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Bowdoin Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>AL</b>   |  |
| 5. Social Security Number<br><b>214-38-0783</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>03/15/1919</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>AL</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2307 West Lanvale Street</b>   |  | 10f. Zip Code<br><b>21216</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>3</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>domestic</b>  |  | 16b. Kind of Business/Industry<br><b>housewife</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Katina Barnes / Great-Granddaughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2526 Loyola Southway; Baltimore, Maryland 21215</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Shirley Jones</b>   |  | 22. Name and Address of Facility<br><b>Wylie Funeral Home, P.A.<br/>638 North Gilmer Street; Baltimore, Maryland 21217</b>  |  |  |  |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Polio/septic shock</b><br><b>Gram Negative Bacteremia</b>  |  |   |  |  |  |
| 23b. Part II. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Dementia</b><br><b>Chronic Feeding tube</b>   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  | 23d. Date of delivery<br>Month <b>03</b> Day <b>14</b> Year <b>2007</b>   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br><b>03-14-2007</b>  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>H. Neal Reynolds</b>  |  | 29c. License number<br><b>D27163</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>03-14-2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Neal Reynolds M.D., Bowdoin Hospital of Baltimore</b>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br><b>Shirley Jones</b>   |  |  |  |

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 02457

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irving Leonard Cook, Sr.

2. Date of Death  
Month Day Year

March 14, 2007

3. Time of Death

5:42 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2023 Paulette Road Apt. 3

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore Co.

5. Social Security Number

217-24-6251

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

8. Date of Birth (Month, Day, Year)

Aug. 23, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2023 Paulette Road Apt. 3

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7 Years

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Dredging Engineer

16b. Kind of Business/Industry

Marine Maintenance

17. Father's Name (First, Middle, Last)

Griffith Earl Cook

18. Mother's Name (First, Middle, Maiden Surname)

Charles Anna Jones

19a. Informant's Name/Relationship (Type, Print)

Mr. Lenny Cook (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1937 Orchard Point Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

3/17/2007

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Duda-Ruck Funeral Home of Dundalk, Inc.

22. Name and Address of Facility

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

b. Congestive heart failure

Due to (or as a consequence of):

c. Type 2 diabetes mellitus

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Grace A. Cordts MD

29c. License number

035763

29d. Date signed (Month, Day, Year)

March 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace A. Cordts MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

John B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

07-01990  
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 00458

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Christopher Claude Clarke

2. Date of Death

Month Day Year  
March 13, 2007

3. Time of Death

2131 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number  
216-31-39246. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
18 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth (MM/DD/YYYY)  
March 21, 19889. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location  
Baltimore10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

3016 Mayfield Ave.

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Patterson High

17. Father's Name (First, Middle, Last)

Devon Hezekiah Clarke

18. Mother's Name (First, Middle, Maiden Surname)

Anita A. Graham

19a. Informant's Name/Relationship (Type, Print)

Anita A. McDonald

19b. Mailing Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3016 Mayfield Ave. Baltimore, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, funeral home, or other place)

Dulaney Valley Memorial Gardens

Date

3/22/2007

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Parkville 8800 Harford Rd. Parkville, MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wounds of chest and thigh

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

## Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

Mar 13, 2007

28b. Time of Injury

2022 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Local Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3100 blk Clifmont Avenue, Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD, Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

State

Registrar

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08459

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph F. DiMarino, Sr.</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 15, 2007</b>  |  | 3. Time of Death<br>M<br><b>2:30 P</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>10 Lombardy Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>317-09-4297</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 4, 1919</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>10 Lombardy Drive</b>  |  |   |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 Years</b><br>College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinest</b>  |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Salvatore DiMarino</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Antoinette DiGiambatista</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Maxine DiMarino (Wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 Lombardy Drive Dundalk, Maryland 21222</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Mem. Gdns.</b>   |  | Date<br><b>3/19/2007</b>   |  | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypoxia</b><br>a. Due to (or as a consequence of):<br><b>Dementia</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death  |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown                        |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D55306</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 15, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis H. Odie, M.D. 9106 Philadelphia Rd. Balt. MD 21237</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 03460

1- For State Registrar

1. Decedent's Name (First, Middle, Last)

Todd Denisuk

2. Date of Death

Month Day Year  
March 16, 2007

3. Time of Death

1751 hrs

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore County

5. Social Security Number

217-82-4392

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days Hours Min.

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

April 7, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Eastwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7138 Eastbrook Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Daniel S. Denisuk

18. Mother's Name (First, Middle, Maiden Surname)

Joan Marion Barth

19a. Informant's Name/Relationship (Type, Print)

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mrs. Margaret A. Denisuk

7138 Eastbrook Avenue Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

3/21/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Aregon E. Reed*

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia and fibrosis of lungs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED

#23a, 27, per ME, g866, 4/2/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Margarita Korell*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 17, 2007

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

*Kevin B. Spiller*

Baltimore, MD 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|   |   |                                     |
|---|---|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><i>Leona Durant</i> | 2. Date of Death<br>Month <i>March</i> Day <i>15</i> Year <i>2007</i> | 3. Time of Death<br><i>0756 hrs</i> |
|---|---|-------------------------------------|

|  |  |                                   |
|--|--|-----------------------------------|
| 4a. Facility Name (if not institution, give street and number)<br><i>4 N. Mount Street</i> | 4b. City, Town, or Location of Death<br><i>Baltimore</i> | 4c. County of Death<br><i>N/A</i> |
|--|--|-----------------------------------|

|   |  |  |                                |                                |  |  |
|---|--|--|--------------------------------|--------------------------------|--|--|
| 5. Social Security Number<br><i>216-28-6004</i> | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>72</i> Yrs. | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><i>04-26-1934</i> | 9. Birthplace (State or Foreign Country)<br><i>md.</i> |
|---|--|--|--------------------------------|--------------------------------|--|--|

|                             |                           |  |  |
|-----------------------------|---------------------------|--|--|
| Usual Residence of Decedent |                           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10a. State<br><i>md.</i>    | 10b. County<br><i>N/A</i> | 10c. City, Town or Location<br><i>Baltimore</i>  |  |

|   |                               |   |
|---|-------------------------------|---|
| 10e. Street and Number<br><i>4 N. Mount St.</i> | 10f. Zip Code<br><i>21223</i> | 10g. Citizen of What Country?<br><i>USA</i> |
|---|-------------------------------|---|

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br><i>Black</i><br>Specify: |
|--|--|--|--|

|  |  |   |
|--|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (14 or 5+) <i>N/A</i> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>private duty nurse</i> | 16b. Kind of Business/Industry<br><i>Greater Rana. Nursing Home</i> |
|--|--|---|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br><i>Robert Sawyer Sr.</i> | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mamie Johnson</i> |
|---|---|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Artha Johnson-daughter</i> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1305 S. Glyndon Ave. Balto. md, 21223</i> |
|---|---|

|   |  |                        |  |
|---|--|------------------------|--|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Harmon Forest</i> | Date<br><i>3-23-07</i> | 20c. Location - City or Town, State<br><i>Owings Mills, MD</i> |
|---|--|------------------------|--|

|   |  |
|---|--|
| Signature of Funeral Service Licensee<br><i>Audrey M. Wallace</i> | 22. Name and Address of Facility<br><i>3405 W. Franklin St. Balto. Maryland</i><br><i>Nancy M. Wallace Funeral Service</i> |
|---|--|

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

|   |  |
|---|--|
| Immediate Cause (Final disease or condition resulting in death)<br><i>a. Atherosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of): |  |
|---|--|

|   |  |
|---|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b.</i><br>Due to (or as a consequence of): |  |
|---|--|

|   |  |
|---|--|
| <i>c.</i><br>Due to (or as a consequence of): |  |
|---|--|

|   |  |
|---|--|
| <i>d.</i><br>Due to (or as a consequence of): |  |
|---|--|

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |   |
|---|---|
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene |
|---|--|

|   |  |                     |  |                                   |
|---|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
|---|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|   |  |  |  |
|---|--|--|--|
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Theodore M. King, Jr., MD.</i> | 29c. License number<br><i>O.C.M.E.</i> | 29d. Date signed (Month, Day, Year)<br><i>March 16, 2007</i> |
|---|--|--|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br><i>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</i> |
|---|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><i>MAR 19 2007</i> | 32. Registrar's Signature<br><i>Leona Durant</i> |
|---|--|

|                 |
|-----------------|
| State Registrar |
|-----------------|

Baltimore, MD 21215-0036  
To Be Completed by Funeral Director

Physician/Medical Examiner  
To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268-0760

DHMH 17 Rev 1/2001  
OCME 2006

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08462

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA L. DOYLE

2. Date of Death

MARCH 12, 2007 01:45AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-24-0254

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 13, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9603 Oak Summitt

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

John D. Hummel

18. Mother's Name (First, Middle, Maiden Surname)

Leona E. Ebberts

19a. Informant's Name/Relationship (Type. Print)

John Doyle-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Woodbridge Place, Pueblo, CO 81001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL AND CREMATION SERVICES

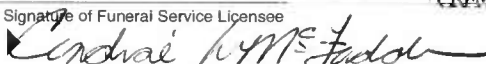
Date

3-16-07

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

EVANS FUNERAL CHAPEL AND CREMATION SERVICES

8800 Harford Road  
Parkville, MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

SEPTIC SHOCK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. METASTATIC COLON CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COAGULOPATHY

LACTIC ACIDOSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D31826

29d. Date signed (Month, Day, Year)

3-12-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L. LINTHICUM M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08463

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Terry L. Ermer

2. Date of Death  
Month Day Year  
March 10, 20073. Time of Death  
1150 hrs4a. Facility Name (if not institution, give street and number)  
3146 Wallford Drive Apartment 2C4b. City, Town, or Location of Death  
Dundalk4c. County of Death  
Baltimore CountyFuneral  
Director5. Social Security Number  
217-62-42866. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
51 Yrs.8. Date of Birth (MM/DD/YYYY)  
July 8, 19559. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Dundalk10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
3146 Wallford Drive Apt. C10f. Zip Code  
2122210g. Citizen of What Country?  
United States11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black,  
White, etc.  
Specify: White15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
12 Years16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)  
Stationary Engineer16b. Kind of Business/Industry  
Engineering17. Father's Name (First, Middle, Last)  
Kenneth Ermer18. Mother's Name (First, Middle, Maiden Surname)  
Dorothy Fuller19a. Informant's Name/Relationship (Type, Print)  
Mr. David Ermer (Son)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
1438 Bonnett Lane Laurel, Maryland 2070720a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery,  
crematory or other place)  
Hilltop Service Corp.Date  
3/14/200720c. Location - City or Town, State  
Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)  
a. Cirrhosis of liver  
Due to (or as a consequence of):Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, per ME, g866, 4/12/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No 9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number  
O.C.M.E.29d. Date signed (Month, Day, Year)  
March 11, 2007

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Terry Lee Ermer

State  
Registrar

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 08464

Physician/  
Medical Examiner

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Barbara Ann Eder

2. Date of Death  
Month Day Year  
March 11, 2007

3. Time of Death  
1735 hrs

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

212-82-3674

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

July 05, 1961

9. Birthplace, State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State

unk.

10b. County

unk.

10c. City, Town or Location

unk.

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

unk.

10f. Zip Code

unk.

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

09

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bar Tender

16b. Kind of Business/Industry

Bar

17. Father's Name (First, Middle, Last)

Maxmilan Lawrence Eder, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Madeline LoZito

19a. Informant's Name/Relationship (Type, Print)

Mrs. Denise B. Kohlhepp (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9108 Summer Park Drive Baltimore, MD. 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

Date

March 14, 2007

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

*Jeffrey F. Gair, Jr.*

22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Ctr., P.A.  
2325 York Road Timonium, Maryland 21093

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter U. Dying Cause.

(Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Hepatic cirrhosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Pamela E. Southall, MD*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 12, 2007

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

*Barbara A. Eder*

Funeral Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

patient known as "Alvin Flesher"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08465

|  |   |                          |   |   |   |                                      |  |  |  |  |
|--|---|--------------------------|---|---|---|--------------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Alvin R. Flesher                                  |                          |   |   | 2. Date of Death<br>Month Day Year<br>March 15 <sup>th</sup> 2007   |                                      |  |  | 3. Time of Death<br>1418 P.M.                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Sinai Hospital of Baltimore |                          |   |   | 4b. City, Town, or Location of Death<br>Baltimore City  |                                      |  |  | 4c. County of Death                                      |  |
| Funeral<br>Director  | 5. Social Security Number<br>202-28-4136  |                          | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>71 Yrs.   |                                      | 8. Date of Birth (Month, Day, Year)<br>Feb. 26, 1936   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |  |
|  | Usual Residence of Decedent   |                          |   |   |   |                                      |  |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>Baltimore |   | 10c. City, Town or Location<br>Parkville  |   |                                      |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1821 Dunwoody Road   |   |                          |   | 10f. Zip Code<br>21234  |   | 10g. Citizen of What Country?<br>USA |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer |   |                                      | 16b. Kind of Business/Industry<br>Mechanical Engineering   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Stephen A. Flesher  |   |                          |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Petrisko  |                                      |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joanne H. Flesher / wife   |   |                          |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1821 Dunwoody Road; Parkville, MD 21234  |                                      |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.   |   | Date<br>3/17/07   |                                      | 20c. Location - City or Town, State<br>Towson, MD  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                          | 22. Name and Address of Facility<br>Ruck Towson Funeral Home 1050 York Road Towson, MD 21204  |   |   |                                      |  |  |  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Traumatic Brain Injury<br>Due to (or as a consequence of):<br>b. Massive bleeding - temporal fracture<br>Due to (or as a consequence of):<br>c. Multiple spine fracture<br>Due to (or as a consequence of):<br>d. Pelvis fracture<br>Approximate Interval Between Inset and Death |   |                          |   |   |   |                                      |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   |                          | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |   |   |                                      | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                          |   |   |   |                                      | 23a. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   |   |   |                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                      |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |                          | 28a. Date of Injury (Month, Day Year)<br>3/15/2007  |   | 28b. Time of Injury<br>11:45 AM   |                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>Fall out of tree    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                          | 29b. Signature and title of certifier<br>Rhonda Fishel MD   |   | 29c. License number<br>D28855   |                                      | 29d. Date signed (Month, Day, Year)<br>3/15/07   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Rhonda Fishel M.D. 2435 W. Belvedere Ave.; Baltimore, MD 21215   |   |                          |   |   |   |                                      |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 19 2007   |   |                          |   |   | 32. Registrar's Signature<br>   |                                      |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08466

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND

GIESE

2. Date of Death  
Month Day Year  
March 13 20073. Time of Death  
1642 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number  
217-24-26716. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
Yrs. 798. Date of Birth (Month, Day, Year)  
Nov. 26, 19279. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Dundalk10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
7833 Scholar Road10f. Zip Code  
2122210g. Citizen of What Country?  
United States11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) 12 Years  
College (1-4 or 5+)16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
T.V. Technician16b. Kind of Business/Industry  
Television17. Father's Name (First, Middle, Last)  
Emil Giese18. Mother's Name (First, Middle, Maiden Surname)  
Lillian Steigerwald19a. Informant's Name/Relationship (Type, Print)  
Clara I. Giese (Wife)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
7833 Scholar Road Dundalk, Maryland 2122220a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Sacred Ht. of Jesus Cem. 3/16/2007 Dundalk, Maryland20c. Location - City or Town, State  
Dundalk, Maryland21. Signature of Funeral Service Licensee  
[Signature]22. Name and Address of Facility  
Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pulmonary Edema  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
2 weeksSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Congestive Heart Failure  
Due to (or as a consequence of):

2 weeks

c. Small Bowel Obstruction  
Due to (or as a consequence of):

1 month

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)27. Manner of Death  
1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier  
[Signature]29c. License number  
RES-00029d. Date signed (Month, Day, Year)  
March 13, 200730. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
JACQUELINE GARONUK WANG, M.D. 4040 EASTERN AVENUE BALTIMORE, MD 2122431. Date filed (Month, Day, Year)  
MAR 19 200732. Registrar's Signature  
[Signature]State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

441



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08667

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bettie R Gomez

2. Date of Death  
Month Day Year  
March 13 2007  
3. Time of Death  
8:04 P MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

5. Social Security Number

100-32-3043

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

July 21 1943

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 Main St Apt 205

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Larkin Goudy,

18. Mother's Name (First, Middle, Maiden Surname)

Viedell Norris

19a. Informant's Name/Relationship (Type. Print)

Renee Goudy / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3527 Pinewoods Place Laurel MD 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven

Date

3/21/2007

20c. Location - City or Town, State

Silver Spring, MD

21. Signature Funeral Service Licensee

Shan &amp; Wilk

22. Name and Address of Facility

Fleck Funeral Home  
7601 Sandy Spring Rd Laurel MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cervical Spine Fracture

Due to (or as a consequence of):

b. Ventricular Tachycardia

Due to (or as a consequence of):

8 hours

c. Due to (or as a consequence of):

8 hours

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

March 13, 2007

28b. Time of Injury

12:30 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driving her car and lost control

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Gorman &amp; 8th streets, Laurel MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Critical Care physician

29c. License number

D0060563

29d. Date signed (Month, Day, Year)

MARCH, 13, 2007

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

LAUREL REGIONAL HOSPITAL

7300 VAN DUSEN ROAD, LAUREL, MARYLAND 20707

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Shan &amp; Wilk

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 00468

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Jean Hawkins

2. Date of Death

March 13 2007

3. Time of Death

11:10a M

4a. Facility Name (If not institution, give street and number)

Continuum Care At Sykesville

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

232-36-9610

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 1 1927

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

521 Manor Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LPN

16b. Kind of Business/Industry

health care

17. Father's Name (First, Middle, Last)

Martin Lantz

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Arms

19a. Informant's Name/Relationship (Type, Print)

Robert Reinhardt Jr. (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5110 Mount Carmel Rd., Manchester, MD 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lake View Memorial

Date

3-17-07

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

▶ *Paige Haight Herbert*

22. Name and Address of Facility Haight Funeral Home &amp; Chapel

P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Lung Cancer

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lasta. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *[Signature]*

29c. License number

D 43725

29d. Date signed (Month, Day, Year)

3/14/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MATMOUD 19 Ridge Road Westminster 21157

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

▶ *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No. 2007 08469

1- For State Registrar

|   |   |   |   |  |   |   |  |  |
|---|---|---|---|--|---|---|--|--|
| Physician /Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ruth M. Hoerner</b>  |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>4:35 P M</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Heritage Meridian Ctr.</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral Director  | 5. Social Security Number<br><b>217-40-3051</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 21, 1938</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore City</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>6721 Fait Avenue</b>   |  | 10f. Zip Code<br><b>21224</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>8 years</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Kitchen Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Christian C. Hoerner, Sr.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Grob</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Ricky Citrano (Cousin)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1207 White Avenue Baltimore, Maryland 21237</b>   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Ht. of Jesus Cem.</b>   |  | 20c. Location - City or Town, State<br><b>3/10/2007 Dundalk, Maryland</b>   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):<br><b>b. CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><b>c. HYPERTENSION</b><br>Due to (or as a consequence of):<br><b>d. DEPRESSION</b> |   |   |  |   |   |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) |  | 23d. Date of delivery<br>Month Day Year   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |
| 27. Manner of death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Savinda K. Tuller MD</b>  |   | 29c. License number<br><b>D 27188</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/19/07</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Savinda K. Tuller 2 Market Place Dundalk MD 21222</b>  |   |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08470

|                                     |  |  |   |  |   |  |   |  |  |  |   |  |
|-------------------------------------|--|--|---|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edna Hollingshead</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 15, 2007</b>   |  |   |  | 3. Time of Death<br><b>10:04 A<sup>M</sup></b>   |  |   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Ctr.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>215-12-3194</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1920</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |
|                                     | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|                                     | 10e. Street and Number<br><b>7624 Old Battle Grove Road</b>  |  |   |  | 10f. Zip Code<br><b>21222</b>   |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><b>11 Years</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>James Thompson</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Cannon</b>   |  |  |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print) (Son)<br><b>Mr. James E. Hollingshead</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2407 Maple Road Edgemere, Maryland 21219</b>  |  |   |  |  |  |   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gdns.</b>  |  | Date<br><b>3/19/2007</b>  |  | 20c. Location - City or Town, State<br><b>Middle River, MD</b>   |  |   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b> |  |  |  |   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):<br><b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>DIABETES</b><br>Due to (or as a consequence of):<br><b>DEMENCIA</b> |  |   |  |   |  |   |  |  |  |   |  |
|                                     | Approximate Interval Between Onset and Death   |  |   |  |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|                                     |  |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|                                     |  |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                     |  |
|                                     |  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><i>Savinder K. Tuli MD</i>   |  |   |  | 29c. License number<br><b>D27118</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/15/07</b> |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Savinder K. Tuli 2 Maryland Place Dundalk 21222 MD</b>  |  |   |  |   |  |   |  |  |  |   |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08471

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Louise Hyde

2. Date of Death

3/8/07

Day Year

3. Time of Death

1:30 pm M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6610 Allegheny Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

216-50-8256

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/12/47

9. Birthplace (State or Foreign Country)

Watertown, NY

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6610 Allegheny Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Art

17. Father's Name (First, Middle, Last)

Frederick Hyde

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Peavey

19a. Informant's Name/Relationship (Type, Print)

John D. Kline, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6610 Allegheny Avenue, Takoma Park, MD 20912

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

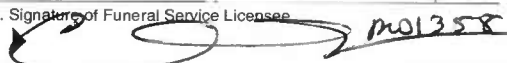
Date

3/14/07

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rapp Funeral and Cremation Svs.

933 Gist Avenue Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anaplastic Astrocytoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

DC-11864

29d. Date signed (Month, Day, Year)

3/16/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. M. B. Dunn

2021 K Street, N.W. Washington, DC 20006

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature



Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08472

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys O. Hudson

2. Date of Death

March 14, 2007 Year

3. Time of Death

1:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Althea Woodlands Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

181-16-4067

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04/16/1920

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1000 Dale View Dr.

10f. Zip Code

20852-

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Senior Caregiver

16b. Kind of Business/Industry

Homecare

17. Father's Name (First, Middle, Last)

John Edgar

18. Mother's Name (First, Middle, Maiden Surname)

Maude Della Webster

19a. Informant's Name/Relationship (Type, Print)

James Gwyn/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1845 Harvard St. NW #623 Washington, DC 20009-

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Mar 21  
200720c. Location - City or Town, State  
Beltsville, Maryland

21. Signature of Funeral Service Licensee

[Signature] 201358

Rapp Funeral &amp; Cremation Services

933 Gist Ave. Silver Spring, Maryland 20910-

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Alzheimer Disease

Due to (or as a consequence of):

15 years

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending  
investigation  
3 ☐ Accident 4 ☐ Suicide  
5 ☐ Could not be  
determined  
6 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 21900

29d. Date signed (Month, Day, Year)

3-15-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith H, M.D. 7610 Carroll Ave #200 Takoma Park, MD

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. For State Registrar

Amend Items

24a, 25, 26, 27, 29a per dr. #865, 03/19/07dhb

Certificate of Death

Reg. No.

2007 08473

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ella Hickman</b>  |  |  |  | 2. Date of Death<br>Month <b>03</b> Day <b>04</b> Year <b>07</b>  |  | 3. Time of Death<br><b>23:57 M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>212-30-5507</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 12, 1917</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4700 Harford Road</b>   |  | 10f. Zip Code<br><b>21214</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>clerk</b>  |  | 16b. Kind of Business/Industry<br><b>department store</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>unk</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unk</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Trudy Harris/grand daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2902 Bayonne Avenue Baltimore, MD 21214</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>State Anatomy Board</b>   |  | 20c. Date<br><b>03-08-07</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, MD 21201</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |
| 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Renal failure</b><br>Due to (or as a consequence of):<br>c. <b>dehydration</b><br>Due to (or as a consequence of):<br>d. <b>dementia</b> |  | Approximate Interval Between Onset and Death  |  | 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)<br><b>03-08-07</b>   |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>64493</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>03-08-07</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Yofana Range, 821 N. Eutaw Street, MD 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08474

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EDNA HAWKINS</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>19</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>2:10A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>219-10-8321</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>APRIL 02, 1918</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>124 W. Franklin Street</b>   |  | 10f. Zip Code<br><b>21201</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African American</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Catering</b>  |  | 16b. Kind of Business/Industry<br><b>Food Service</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Stepp</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Stepp</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARVA TAYLOR - Granddaughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2016 Kelbourne Road - Baltimore, Maryland 21237</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CORRISON FOREST</b>  |  | 20c. Location - City or Town, State<br><b>March 21, 2007 Owings Mills, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Wm. M. Wallace</b>  |  | 22. Name and Address of Facility<br><b>Nancy M. Wallace Funeral Service<br/>3405 W. Franklin Street - Baltimore, Maryland 21229</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Breast Cancer</b><br><b>b. Hypertensive Cardiovascular Disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br><b>d.</b> |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Rosita R. Cruz M.D.</b>   |  | 29c. License number<br><b>00030355</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 19, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08475

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin S. Huson

2. Date of Death

Month

Day

Year

03/

14

2007

3. Time of Death

13:26 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air, Maryland

4c. County of Death

Harford

5. Social Security Number

219-14-1037

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

01/26/1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1□ Yes 2X No

10e. Street and Number

7417 Goettner Road

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2□ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Full Time Technician

16b. Kind of Business/Industry

Maryland National Guard

17. Father's Name (First, Middle, Last)

Edwin M. Huson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret B. Burkins

19a. Informant's Name/Relationship (Type, Print)

Eleanor G. Huson (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7417 Goettner Road - Kingsville, Maryland 21087

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gdns.

Date

03/17/2007

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home, P.A.

11750 Belair Road - Kingsville, Maryland 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure.

Due to (or as a consequence of):

b. Acute Interstitial Pneumonitis

Due to (or as a consequence of):

c. Acute, chronic Renal failure

Due to (or as a consequence of):

d. Hypertension.

Approximate Interval Between Onset and Death

3 weeks.

3 yrs.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1□ Yes 2□ No  
9□ Unknown

23c. If yes, outcome of pregnancy

1□ Live birth 2□ Fetal death 3□ Ectopic pregnancy  
4□ Pregnant at time of death 5□ Other (specify)  
9□ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysmal Repair

23e. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation  
2□ Accident 6□ Could not be determined  
3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. D. Parekh

29c. License number

D0018424

29d. Date signed (Month, Day, Year)

Mar-15-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. D. PAREKH MD. 1108 HARFORD ROAD, FALLSTON MD. 21047

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

E. F. Lassahn

ORIGINAL

3/14/07 1320 PM  
Baltimore, Maryland 21215-0036Huson, Edwin M. 670  
Division of Vital Records, P.O. Box 88760, 4

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #5 per FH, C\*69, 7/25/07 WS  
State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08476

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARY ELIZABETH HARRIS</b>  |  | 2. Date of Death<br>Month <b>MAR.</b> Day <b>12</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>2:00P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>3912 LINK AVENUE</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| 5. Social Security Number<br><b>216-68-9174</b><br><b>013-40-4419</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  |  |
| 8. Date of Birth<br>Month <b>February</b> Day <b>20</b> Year <b>1949</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore County</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3912 Link Avenue</b>  |  | 10f. Zip Code<br><b>21237</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Howard Babyok</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Georgette Nepus</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald P Reitz (Husband)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3912 Link Avenue Baltimore, Maryland 21236</b>  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St Joseph Church Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |
| 20d. Date<br><b>March 16 2007</b>   |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b> |  | Approximate Interval Between Onset and Death<br><b>1 month</b>   |  |   |  |
| Due to (or as a consequence of):<br><b>Osteomyelitis</b>  |  | <b>5 months</b>  |  |   |  |
| Due to (or as a consequence of):<br><b>Decubitus Ulcers</b>   |  | <b>6 months</b>  |  |   |  |
| Due to (or as a consequence of):<br><b>Anoxic brain injury</b>  |  | <b>8 months</b>  |  |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pancreatic Cancer</b><br><b>Myotonic Dystrophy</b><br><b>Diabetes Mellitus</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined        |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |
| 29c. License number<br><b>D 57444</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 13, 2007</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alexander Chen MD PO Box 19099 Towson, MD 21284</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2007 08477

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Mary Windsor Harris

2. Date of Death  
Month Day Year  
March 11, 2007

3. Time of Death  
0845 hrs

4a. Facility Name (if not institution, give street and number)  
Sinai Hospital

4b. City, Town, or Location of Death  
Baltimore City

4c. County of Death

5. Social Security Number  
652-07-4917

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
8 Yrs.

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)  
June 12, 1998

9. Birthplace (State or Foreign Country)  
Colorado

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Baltimore

10c. City, Town or Location  
Ruxton

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
1208 Berwick Road

10f. Zip Code  
21204

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Student

16b. Kind of Business/Industry  
School

17. Father's Name (First, Middle, Last)  
Edward B. Harris, III

18. Mother's Name (First, Middle, Maiden Surname)  
Laura A. Pilachowski

19a. Informant's Name/Relationship (Type, Print)  
Edward B. Harris, III (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
1208 Berwick Road, Ruxton, MD. 21204

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Loudon Park Cemetery

Date  
3/15/ 07

20c. Location - City or Town, State  
Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Loudon Park Funeral Home  
3620 Wilkens Ave., Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Sepsis due to pneumonia  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 ☒ UNPENDED

2 ☒ AMENDED  
#1, 23a, 27, per ME, g866, 4/19/07 TT

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other

27. Manner of Death  
1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number  
O.C.M.E.

29d. Date signed (Month, Day, Year)  
March 12, 2007

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

*[Signature]*

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No

2007 08478

2007 08 17

1- For State Registrar

Physician/Medical Examiner

Funeral Director

Reg. No.

1. Decedent's Name (First, Middle, Last)

2. Date of Death

3. Time of Death

4a. Facility Name (if not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or Foreign Country)

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

23f. Was an autopsy performed?

23g. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner?

26. Place of Death (Check only one)

27. Manner of Death

28a. Date of Injury

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08479

1- For State Registrar

Certificate of Death

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA ROBERTA JACKSON</b>  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 12, 2007</b>   |  | 3. Time of Death<br><b>5:30 PM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FUTURE CARE OF CALTON</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-12-9367</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 28, 1923</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |   | 10a. State<br><b>MD.</b>  |  |  |
| To Be Completed by Funeral Director  | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>736 S. ELLWOOD AVE.</b>   |   | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>BEAUTICIAN</b>          |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BEAUTICIAN</b>   |   | 16b. Kind of Business/Industry<br><b>BEAUTY SHOP</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN ROWELL</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>INEZ TAYLOR</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>EARL JACKSON</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>736 S. ELLWOOD AVE. BALTO, MD. 21224</b>          |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE</b>  |  | 20c. Location - City or Town, State<br><b>MARCH 15 2007 HOWARD CO., MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Thomas J. Skarda</b>   |   | 22. Name and Address of Facility<br><b>SKARDA F.H. 8529 HILSON ST BALTO., MD 21224</b>  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Advanced Dementia.</b><br>Due to (or as a consequence of):<br>b. <b>Decubitus ulcer.</b><br>Due to (or as a consequence of):<br>c. <b>Malnutrition</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Skarda</b>   |  | 29c. License number<br><b>00055171</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3/12/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SEBASTIAN JOHN 3023 Eastern Avenue Baltimore MD 21224</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08480

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |   |   |  |
|--|---|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Lawrence Norbert Juchs  |  |  |   | 2. Date of Death<br>Month Day Year<br>March 13 2007   |  |  |   | 3. Time of Death<br>1:39 P M  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>1116 Old Carriage Road  |  |  |   | 4b. City, Town, or Location of Death<br>Glen Arm  |  |  |   | 4c. County of Death<br>Baltimore County   |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-28-5697  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>76 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 12, 1931 |   | 9. Birthplace (State or Foreign Country)<br>Baltimore, Md.  |  |
|  | Usual Residence of Decedent   |  |  |   | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore County                      |   | 10c. City, Town or Location<br>Glen Arm   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 10e. Street and Number<br>11116 Old Carriage Road   |  |  |   | 10f. Zip Code<br>21057  |  |
|  | 10g. Citizen of What Country?<br>United States  |  |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Assistant Principle  |  |  |   | 16b. Kind of Business/Industry<br>Baltimore Co. Schools   |  |  |   | 17. Father's Name (First, Middle, Last)<br>Lawrence John Juchs  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Josephine E. Sappington  |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Jean S. Juchs (Wife)   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11116 Old Carriage Road, Glen Arm, Maryland 21057  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Belair Mem. Gdns.   |  |  |   | 20c. Location - City or Town, State<br>March 16, 2007 Belair, Maryland  |  |
|  | 21. Signature of Funeral Service Licensee<br>[Signature]  |  |  |   | 22. Name and Address of Facility<br>Peaceful Alternatives Funeral & Cremation Ctr., P.A.<br>2325 York Road, Timonium, Maryland 21093  |  |  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>pancreatic cancer<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  |  |   | 23d. Date of delivery<br>Month Day Year   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day Year)   |   |  |  | 28b. Time of Injury<br>M  |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature and title of certifier<br>[Signature]  |   |  |
| 29c. License number<br>D0030122  |   |  |  | 29d. Date signed (Month, Day, Year)<br>March 14, 2007   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lawrence J. Snyder, 7505 Osler Dr 308 Towson, Md. 21204 |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 19 2007   |   |  |  | 32. Registrar's Signature<br>[Signature]  |   |  |  | State Registrar   |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For State Registrar

Certificate of Death

Reg. No. 2007 08181

**Physician /Medical Examiner**  
**Funeral Director**  
**Physician /Medical Examiner**  
**State Registrar**

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MILLARD C. JENKINS JR.</b>   |  | 2. Date of Death<br>Month <b>Mar</b> Day <b>15</b> Year <b>2007</b>   |   | 3. Time of Death<br><b>15:13 M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>412-22-7321</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81-82</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>12-4-1925</b>   | 9. Birthplace (State or Foreign Country)<br><b>TENN</b>  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>727 DRUID LAKE SR APT 7E</b>   |  | 10f. Zip Code<br><b>21215</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-12-</b> College (1-4or 5+) <b>-0-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FITNESS ASSISTANT</b>   |   | 16b. Kind of Business/Industry<br><b>WELLNESS CENTER</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MILLARD JENKINS, SR.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JESSIE BASS</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RECARDO MILLARD (BROTHER)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>421 COBB CREEK PKWY. PHILADELPHIA, PENNA. 19143</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VETERANS 3-23-2007 OWINGS MILLS, MD.</b>   |   | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><i>Jonathan D. Hibner</i>  |  | 22. Name and Address of Facility<br><b>PHILLIPS FUNERAL HOME, P.A.<br/>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Septic Shock</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>13 days</b><br><b>5 months</b> |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death Check only one<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Soon Mee Chung M.D.</i>   |  | 29c. License number<br><b>AT2438946</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Mar 15, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Soon Mee Chung, M.D. Union Memorial Hospital MD</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08482

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mildred L. Johnson

2. Date of Death

March 16 2007

3. Time of Death

6:55 A M

4a. Facility Name (If not institution, give street and number)

3613 Croydon Rd.

4b. City, Town, or Location of Death

GUYMAN OAK

4c. County of Death

BALTIMORE

5. Social Security Number

374-39-1780

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 31, 1938

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

GUYMAN OAK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3613 Croydon Rd.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ANALYST

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

ANDREW JONES

18. Mother's Name (First, Middle, Maiden Surname)

MOZELLA CRITCHFIELD

19a. Informant's Name/Relationship (Type, Print)

JAYSON JOHNSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3613 Croydon Rd, Guyman Oak MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

United Mem. Gardens

Date

3-21-07

20c. Location - City or Town, State

PLYMOUTH MI

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary P. March FH 270 Fredhilton Russ Balto MD 21209

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Amyotrophic Lateral Sclerosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
6 yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D73906

29d. Date signed (Month, Day, Year)

March 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Wiener, MD; 1830 E Monument St.; Baltimore, MD 21209

31. Date filed (Month, Day, Year)

MAR 17 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. For State Amend #5, per FD G865, 3/26/07 TT **State of Maryland / Department of Health and Mental Hygiene** **Certificate of Death** **Reg. No.** **2007 08483**

|  |  |   |   |  |  |   |  |  |  |
|--|--|---|---|--|--|---|--|--|--|
| <b>Physician / Medical Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Emma M. Keyes</b>   |   |   | 2. Date of Death<br>Month <b>3</b> Day <b>16</b> Year <b>07</b>  |  | 3. Time of Death<br><b>2:45 PM</b>  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |  |  |
| <b>Funeral Director</b>  | 5. Social Security Number<br><b>217-07-137</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>10-16-1920</b>   |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Parkville</b>  |  |  |
| <b>To Be Completed by Funeral Director</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   | 10e. Street and Number<br><b>3504 North Wind Road</b>  |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Kelbel</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Snyder</b>  |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carole Miller - Daughter</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3504 North Wind Road Parkville, MD 21234</b> |  |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | Date<br><b>03/21/2007</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Charles J. Miller</b>  |   |   | 22. Name and Address of Facility<br><b>5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214</b>   |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Hypoxia</b><br>Due to (or as a consequence of):<br><b>Multi System Organ Failure</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |  |   |  | Approximate Interval Between Onset and Death   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred              |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Behari MD</b>  |  |   | 29c. License number<br><b>D64408</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/16/07 330p</b>                                  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ajay Behari 9000 Franklin Square Drive, Baltimore, MD 21237</b>   |  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |  |  |

Keyes, Emma  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08484

1- For  
State  
Registrar

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN KRASNODEMSKA</b>   |  |  |  | 2. Date of Death<br>Month <b>03</b> Day <b>13</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>9:50 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-20-6835</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 21, 1925</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>BALTO CO.</b>  |  | 10c. City, Town or Location<br><b>DUNDALK</b>                           |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>108 HIGHSIRE CT.</b>  |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>FRANCIS KRASNODEMSKA</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERONICA WILCZEK</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>DENISE DAVIS</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 HIGHSIRE CT. DUNDALK, MD. 21222</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. STANISLAUS</b>  |  | 20c. Location - City or Town, State<br><b>BALTO., MD.</b>  |  | 20d. Date<br><b>MARCH 16 2007</b>                                       |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Thomas J. Sparda J.</b>   |  |  |  | 22. Name and Address of Facility<br><b>SKARDA T.H. 2529 HOPSON ST. BALTO., MD. 21224</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Arteriosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | Approximate Interval Between Onset and Death<br><b>12 hours</b><br><b>10 years</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Insulin Dependent Diabetes Mellitus</b>  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. Ba Yin Ung</b>   |  | 29c. License number<br><b>D17728</b>                                    |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>3/13/07</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ba Yin Ung 900 Franklin Square Drive Balto., MD 21237</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 08485

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eloise Irene King

2. Date of Death

03 14 2007

3. Time of Death

7:58am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare-Hammonds Lane

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

21910 4996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 16 1914

9. Birthplace (State or Foreign Country)

Williamsburg, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1207 Tarrytown lane

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Baltimore City Police Dept.

17. Father's Name (First, Middle, Last)

Robert Henry

18. Mother's Name (First, Middle, Maiden Surname)

Grace Richer

19a. Informant's Name/Relationship (Type, Print)

Joyce A Fischer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 Tarrytown Lane Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cem. March 16 2007

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home Inc

7401 Belair Road Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Dementia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D53462

29d. Date signed (Month, Day, Year)

3/14/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jude M. Pines MD 7845 Oakwood Road Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 18

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08486

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRIS RITA

KOTZ

2. Date of Death

MARCH 14 2007

3. Time of Death

9:30 A M

4a. Facility Name (If not institution, give street and number)

7219 PARK HEIGHTS AVENUE APT. 107

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-20-4674

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

01/23/1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7219 PARK HEIGHTS AVENUE #107

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS

CRYSTAL

18. Mother's Name (First, Middle, Maiden Surname)

EMMA

BARR

19a. Informant's Name/Relationship (Type, Print)

LEONARD KOTZ / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7219 PARK HEIGHTS AVENUE #107-BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH JACOB CONG.

Date

03/16/2007

20c. Location - City or Town, State

FINKSBURG, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urinary sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Obstructive uropathy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

019914

29d. Date signed (Month, Day, Year)

3/17/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irat Finc 10753 Falls Rd Lutherville Md 21093

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 03487

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NAOMI LeCompte

2. Date of Death

Month Day Year

3 15 07

3. Time of Death

12 45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

James Randallstown 9109 Liberty Road Randallstown MD 21133

4b. City, Town, or Location of Death

4c. County of Death

Baltimore

5. Social Security Number

214-07-9317

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

5-6-1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2803 Bayonne Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elevator Dispatcher

16b. Kind of Business/Industry

Office Building

17. Father's Name (First, Middle, Last)

George A. LeCompte

18. Mother's Name (First, Middle, Maiden Surname)

Katie J. Knefely

19a. Informant's Name/Relationship (Type, Print)

Ms. Katherine C. Watson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2803 Bayonne Ave., Baltimore, MD 21214

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 3/16/2007

Date

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

Charles F. Miner

22. Name and Address of Facility

Leonard J. Ruck, Inc. Baltimore, MD 21214

5305 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jocelyn N. El-Sayed

29c. License number

D0056414

29d. Date signed (Month, Day, Year)

3-14-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyn N. El-Sayed 9109 Liberty Road, Randallstown, MD 21133

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Jocelyn N. El-Sayed

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2007 08488

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Lang

2. Date of Death

MARCH 5, 2007

3. Time of Death

10:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MAYFIELD HOUSE

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

213-32-0108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 17, 1934

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO.

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

123 FAIRFIELD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME IMP.

16b. Kind of Business/Industry

CONTRACTOR

17. Father's Name (First, Middle, Last)

JOSEPH LANE

18. Mother's Name (First, Middle, Maiden Surname)

ANNA BLOCKER

19a. Informant's Name/Relationship (Type, Print)

PATRICIA LANE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 S. CALLENDER ST. BALTO., MD. 21201

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BAYVIEW CREM.

Date

MARCH 12, 2007

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

D. Thomas J. Skarda J.

22. Name and Address of Facility

2829 HUDSON ST. BALTO., MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Thrombosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dorothy Seay

29c. License number

D0053337

29d. Date signed (Month, Day, Year)

3-9-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Seay, MD 2835 Smith Avenue Baltimore, Md 21209

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Dorothy Seay

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 00489

|  |  |             |   |  |  |  |  |   |  |
|--|--|-------------|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT PROCTOR LINZEY, SR</b>               |             |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>11</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>0645 M</b>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien at Bel Air</b> |             |   |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  | 4c. County of Death<br><b>Harford</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-26-0298</b>  |             | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 25, 1930</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent  |             |   |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>3129 Rosalie Avenue</b>   |  |             |   | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                          |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |             |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b> |  | 16b. Kind of Business/Industry<br><b>Baltimore City Schools</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Harry Linzey</b>  |  |             |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Louise Droll</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mike Linzey-Son</b>   |  |             |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>705 Carlton Way-Bel Air, Maryland 21014</b>  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVANS FUNERAL CHAPEL AND CREMATION SERVICES Bel Air</b>  |  | Date<br><b>3-20-07</b>   |  | 20c. Location - City or Town, State<br><b>Forest Hill, Maryland</b>                              |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Condrie L McFadden</i>   |  |             |   |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL AND CREMATION SERVICES 8800 Harford Road Parkville, MD 21234</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |             |   |  |  |  |  | Approximate Interval Between Onset and Death                |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |             | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown       |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEVERE MALNUTRITION, HYPERTENSION, ANEMIA</b>   |  |             |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |             | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |             | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |             |   |  |  | 28d. Describe how injury occurred  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |             |   |  |  |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |             |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Pradhyun MD</i>  |  |             |   |  | 29c. License number<br><b>045344</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>03/11/2007</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURESH DHANJANI, MD, 622 S. UNION AVE, HAYRE DE GRACE, MD 21078</b>   |  |             |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  |             |   |  | 32. Registrar's Signature<br><i>Mark B. Smith</i>  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08490

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

ISABELLA LEISTER

2. Date of Death

MAR 15 2007

3. Time of Death

1750 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MED CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

186-14-3212

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 5, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1305 Providence Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Thomas E. Kerr

18. Mother's Name (First, Middle, Maiden Surname)

Lucy M. Blemings

19a. Informant's Name/Relationship (Type, Print)

Miss Margaret Leister/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1305 Providence Road Towson, Md. 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Co.

Date

3-17-07

20c. Location - City or Town, State

Towson, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. C

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death  
minutes

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

15818

29d. Date signed (Month, Day, Year)

MAR 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Iguchi, M.D., 22 South Greene Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

State Registrar

Certificate of Death

Reg. No. 2007 03191

1- For State Registrar

Physician / Medical Examiner

Funeral Director

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>TRUDI LEE LESSER</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>12</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>6:14P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>4 BLACK CHERRY COURT</b>  |  | 4b. City, Town, or Location of Death<br><b>REISTERSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| 5. Social Security Number<br><b>467-54-7668</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>11/28/1936</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>NY</b>   |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>REISTERSTOWN</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>4 BLACK CHERRY COURT</b>   |  | 10f. Zip Code<br><b>21136</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FLORAL DESIGNER</b>  |  | 16b. Kind of Business/Industry<br><b>FLORAL</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>SIDNEY</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLAIR FRANCIS ALLWEISS</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LORI JOSEPH / DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>421 DOE MEADOW DRIVE-OWINGS MILLS, MD 21117</b>   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON CH120K AMUNO CONG.</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael Eugene</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Philipp M. L. M.D. Deputy</i>   |  |
| 29c. License number<br><b>D18667</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 16, 2007</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip M. L. M.D. 6 Trimble Hill Ct. Lutherville, Md 21093</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  | 32. Registrar's Signature<br><i>James H. Spiller</i>  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician / Medical Examiner

State Registrar



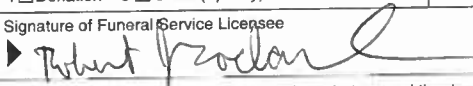
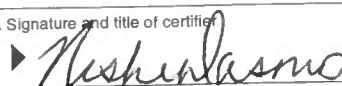

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08492

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |
|---|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Joseph Mooney, Sr.</b>  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>2007</b>  |  | 3. Time of Death<br><b>2:42 P.M.</b>                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>830 South Luzerne Avenue</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>214-22-5139</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 1, 1927</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>830 South Luzerne Avenue</b>   |  |   | 10f. Zip Code<br><b>21224</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b> |  | 16b. Kind of Business/Industry<br><b>Independent Can Company</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>John C. Mooney</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Luckhart</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Patrick (step-son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2005 Jasmine Road Baltimore, Maryland 21222</b>  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus</b>  |  | 20c. Date<br><b>March 19, 07</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Kaczorowski Funeral Home, PA<br/>1201 Dundalk Ave. Baltimore, Md. 21222</b>                   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Dementia</b><br>Due to (or as a consequence of):<br>b. <b>Parkinson's Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  | Approximate Interval Between Onset and Death   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D45876</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 16/2007</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4920 Campbell Blvd, Baltimore, MD 21236</b>  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08693

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA ELIZABETH MINK

2. Date of Death

Month 03 Day 15 Year 07

3. Time of Death

01:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CARROLL HOSPITAL CENTER

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

213-38-5741

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 8 1931

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

412 Second Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

domestic

17. Father's Name (First, Middle, Last)

Lehman Collins

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hatley Roberts

19a. Informant's Name/Relationship (Type, Print)

Herman H. Mink (spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Second Ave., Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evergreen Memorial

Date

3-19-07

20c. Location - City or Town, State

Finksburg, MD

21. Signature of Funeral Service Licensee

► Paige Staught Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. COPD

Due to (or as a consequence of):

b. CHF

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LROSEPSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► B. Bann MD.

29c. License number

D0058580

29d. Date signed (Month, Day, Year)

03/15/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bai KANDU 3233 SUPERIOR LN, B 21, BOWIE, MD 20715

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

► [Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08696

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helen Bond Mazz

2. Date of Death  
Month Day Year  
March 9, 20073. Time of Death  
7:50 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

220-09-4719

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

Feb. 13, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 Maiden Choice Lane, CC206

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Circuit Court of Balto.

17. Father's Name (First, Middle, Last)

John Ross Bond

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dorcas Kirkwood

19a. Informant's Name/Relationship (Type, Print)

Nancy R. Thompson (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

227 Longwood Lane, Bluemont, VA. 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

3/17/07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Ave., Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andy Carz 711 Maiden Choice Lane Catonsville

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2007 08495

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Carolyn Mullins</b>   |  |   |  | 2. Date of Death<br>Month <b>3</b> Day <b>3</b> Year <b>2007</b>   |  | 3. Time of Death<br><b>3:46 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Mercy</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>234-68-6095</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>9/2/42</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>WV</b>  |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>BROOKLYN</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4113 HAGUE AVE.</b>   |  |   |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>SALES REP</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES REP</b>  |  | 16b. Kind of Business/Industry<br><b>AVON</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ALVA GEORGE PHILLIPS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>COLLEEN MARIE STURMS</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>NELLIE J. MULLINS</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4113 HAGUE AVE. BALTIMORE, MD 21225</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN CEMETERY</b>  |  | Date<br><b>3.7.2007</b>  |  | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>K. GREGORY FINK</b> M01148   |  |   |  | 22. Name and Address of Facility<br><b>FINK FUNERAL HOME, P.A.<br/>426 CRAIN HWY S. GLEN BURNIE, MD 21061</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>metastatic adenocarcinoma</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  |   |  | 29c. License number<br><b>17460</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/07</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sandra Ruby MD, MERCY MEDICAL CNT. BALTIMORE MD</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08496

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

THOMAS E. MANDLEY, SR.

2. Date of Death

Month Day Year

MARCH 18, 2007

3. Time of Death

3:10 P M

4a. Facility Name (If not institution, give street and number)

MARINER OF GLEN BURNIE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

214.01.4837

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

89

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 20, 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ODENTON

10d. Inside City Limits

1 Yes 2 No XX

10e. Street and Number

1939 ARTILLERY LANE

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced XX

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No XX No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CAPTAIN

16b. Kind of Business/Industry

MARYLAND STATE POLICE

17. Father's Name (First, Middle, Last)

THOMAS MANDLEY

18. Mother's Name (First, Middle, Maiden Surname)

CLARA LINK

19a. Informant's Name/Relationship (Type, Print)

THOMAS E. MANDLEY, JR. SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1939 ARTILLERY LANE ODENTON, MD 21113

20a. Method of Disposition

1 Burial 2 XX Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BAYVIEW CREMATORY INC

Date

3.19.2007

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

K. GREGORY FINK

M01148

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.

426 CRAIN HWY S. GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

MYOCARDIAL INFARCTION

b. Due to (or as a consequence of):

CAD

c. Due to (or as a consequence of):

PRD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 Yes 2 No

3 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

autopsy

performed?

1 Yes 2 No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 Yes 2 No

25. Was case referred to medical

examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 23530

29d. Date signed (Month, Day, Year)

3-19-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHOK K CHATTERJEE, 3927 ANNAPOLIS ROAD 21227

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2007 08497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Marell

2. Date of Death

3 11 2007

3. Time of Death

11:29 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

334 Wild Willow Way

4b. City, Town, or Location of Death

Severn

4c. County of Death

ANNE ARUNDEL CO.

5. Social Security Number

207389622

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Sept. 17, 1948

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

PA

10b. County

BUCKS

10c. City, Town or Location

Levittown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5722 Fleetwing Dr.

10f. Zip Code

19057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teachers Assistant

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

William Frazier

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Garrett

19a. Informant's Name/Relationship (Type, Print)

Tonya Marell-Bell daughter 334 Wild Willow Way Severn, MD 21144

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenwood Cemetery

Date

Mar. 17, 2007

20c. Location - City or Town, State

Hamilton, N.J.

21. Signature of Funeral Service Licensee

Shelton W. Hackett

22. Name and Address of Facility

HACKETT'S FUNERAL CHAPEL  
814 UPSHURE STREET N.W. WASH DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast Cancer

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shelton W. Hackett

29c. License number

A18320

29d. Date signed (Month, Day, Year)

3/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Frazier, 10753 Falls Rd. WOODVILLE MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Shelton W. Hackett

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2007 08498

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Adele C. Ovelgone</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>16</b> Year <b>2007</b> |  | 3. Time of Death<br><b>12:50 A<sup>M</sup></b> |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FutureCare Canton Harbor Nursing Ctr.</b> |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>         |  | 4c. County of Death<br><b>N/A</b>              |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-16-2353</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                      | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                 |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 29, 1926</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>           |  |  |
| Usual Residence of Decedent  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Dundalk</b>  |  |
| 10e. Street and Number<br><b>8157 Kavanagh Road</b>  |  | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12 Years</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                      |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Adam Popowski</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cecilia Rudzinski</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Henry G. Ovelgone (Husband)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8157 Kavanagh Road Dundalk, Maryland 21222</b> |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licenses<br>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                      |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Lymphoma</b>   |  |  |   |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |   |  |  |
| 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>H0062638</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/16/07</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jonathan Rich P.O. 8801 Hudson St., Suite A, Baltimore, MD 21224</b>  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2007 03100  
2. Date of Death  
Month Day Year  
MARCH 14, 2007 7:07P MPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD N. OWINGS

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-22-5097

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)

7/13/1928

9. Birthplace (State or Foreign  
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RIDGELEIGH

10d. Inside City Limits

1□ Yes 2X No

10e. Street and Number

8544 WATER OAK ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2X Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1X Yes 2□ No

If Yes, Give  
Year or Dates: KOREAN13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FIREFIGHTER

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

CHARLES OWINGS

18. Mother's Name (First, Middle, Maiden Surname)

HELEN BAKER

19a. Informant's Name/Relationship (Type, Print)

MARY OWINGS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8544 WATER OAK ROAD BALTIMORE, MD 21234

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)CENTRE PRESBYTERIAN  
CEMETERY

Date

3/19/2007

20c. Location - City or Town, State

NEW PARK, PA

21. Signature of Funeral Service Licensee

Heath P. Hay

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
Shock, or heart failure. List only one cause of each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. PNEUMONEMIA  
Due to (or as a consequence of):b. CHRONIC OBSTRUCTIVE LUNG DISEASE  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?

1□ Yes 2□ No

9□ Unknown

23c. If yes, outcome of pregnancy

1□ Live birth 2□ Fetal death

4□ Pregnant at time of death

9□ Unknown

3□ Ectopic pregnancy

5□ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

LUNG CANCER IN REMISSION

23e. Did tobacco use contribute to the cause of death?

1X Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an  
autopsy  
performed?

1□ Yes 2X No

24b. Were autopsy findings available  
prior to completion of cause of  
death?

1□ Yes 2X No

25. Was case referred to medical  
examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending  
investigation6□ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1□ Yes 2□ No

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael Joseph Minisohn

29c. License number

D31189

29d. Date signed (Month, Day, Year)

MARCH 15, 2007

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MICHAEL JOSEPH MINISOHN M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 19 2007

32. Registrar's Signature

Heath P. Hay

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2007 08500

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Benjamin F. Pacitto, Sr.</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>2007</b>  |   | 3. Time of Death<br><b>3:00 A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>2326 Sparrows Point Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Edgemere</b>  |   | 4c. County of Death<br><b>Maryland</b>  |  |
| 5. Social Security Number<br><b>218-30-6269</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 28, 1935</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Edgemere</b>  |  |
| 10e. Street and Number<br><b>2326 Sparrows Point Road</b>  |  | 10f. Zip Code<br><b>21219</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 Years</b><br>College (1-4or 5+) <b>Steelworker</b>   |   | 16. Kind of Business/Industry<br><b>Steel Industry</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Pacitto</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Domico</b>  |   | 19. Informant's Name/Relationship (Type, Print)<br><b>Gladys Pacitto (Wife)</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>3/17/2007 Baltimore, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Lung Cancer</b>  |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D30525</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/14/2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Celano, MD 6869 N. Charles St, Baltimore, MD 21204</b>   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 2007</b>  |  | 32. Registrar's Signature<br>  |   |   |  |

State  
Registrar